2020 Annual Meeting
Board of Trustees
Resolutions
## 2020 ANNUAL MEETING
OF THE AOA BOARD OF TRUSTEES
RESOLUTION ROSTER

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SUBJECT: BUREAU ON INTERNATIONAL OSTEOPATHIC MEDICINE – WHITE PAPER III – PRINCIPLES OF INTERNATIONAL ACTIVITY OF OSTEOPATHIC PHYSICIANS

SUBMITTED BY: Bureau on International Osteopathic Medicine (BIOM)

REFERRED TO: AOA Board of Trustees

1 WHEREAS, the American Osteopathic Association Board of Trustees has approved three White Papers (2000, 2005, and 2007) outlining the strategies and planning of the AOA’s international efforts and the attached White Paper III is a combination and update of the three previous Papers; now, therefore, be it

5 RESOLVED, that the AOA Board of Trustees approve the attached White Paper III as the official document of the AOA’s Bureau on International Osteopathic Medicine.

ACTION TAKEN __________________________

DATE ________________________________
The American Osteopathic Association (AOA) recognizes that it and many of its members, component societies, and institutions desire or need to interact with various governmental and regulatory bodies, scientists, educational institutions, and health care practitioners within the international community. It also appreciates that different languages, cultures, customs, and health practices make communication more difficult and increase the potential for miscommunication.

The AOA therefore desires, in all interactions and communications, that information gathering, education, collaboration, and cooperative ventures be conducted in a professional and ethical manner that accurately represents osteopathic medicine as practiced in the United States.

To this end, the AOA has developed this White Paper and stresses the responsibility of integrating ethics and respect for the known history, authority, and relationships currently governing international health and medical policy when communicating information concerning the AOA and the osteopathic profession in the United States to individuals or organizations unfamiliar with same outside the U.S. border.

**HISTORY & PURPOSE**

The AOA has sought input and recommendations from its Bureau of International Osteopathic Medicine (BIOM) since its formation as a Council in 1996. Furthermore, the BIOM interacts directly with the AOA Board of Trustees to formulate and issue pertinent “White Papers” as informational pieces to describe the scope, direction, and activity of the AOA in the international arena.

In 2000, BIOM’s initial recommendations were approved and an International White Paper was issued. The initial White Paper focused upon ethical interactions between components of the AOA and those international health care practitioners and organizations having significant relevance to the osteopathic profession worldwide. Topics included:

1. AOA Official Interactions
2. Interactions with International Governmental Officials and/or Health/Medical Regulatory Bodies
3. Interactions with International Colleges of Medicine or Osteopathy or Their Graduates
4. American Osteopathic Rights in International Settings
5. International “Osteopathic” Rights in the United States
6. International Membership in the AOA

The second White Paper (2005) reaffirmed conclusions reached in the first White Paper (2000) while providing additional background, insight, and direction for expanding and building upon other international interactions. In particular, the second White Paper focused on the following topics related to international directions by the AOA and its members:

1. Communication
2. Identity
The second White Paper also initiated an addendum of *Potentially Significant International Organizations & Groups*, in an attempt to identify organizations and groups within and outside the United States with which the AOA may have contact or correspondence in discussing international osteopathic curricula, accreditation, certification, and/or licensure.

The purpose of this third International White Paper (2007 and 2020) is to review and update previous White Papers and to describe the current and anticipated scope and activity of the American Osteopathic Association in the international arena. It is also intended as an informational document to provide relevant background and perspective for the AOA and its members for responsible decision-making relative to international education, research, practice and health policy. While not all inclusive, the perspective and principles delineated in this third International White Paper should serve as guidelines for most international interactions.

**PREAMBLE**

For those in the United States of America, involvement in global health has grown beyond the moral, humanitarian motives made by individual practitioners and institutions wishing to contribute to the health care needs of populations in underserved nations. Now, for a variety of personal and practical reasons, U.S. physicians and physicians-in-training are also looking at educational and practice opportunities outside the United States. Osteopathic (DO) and Allopathic (MD) medical students increasingly seek safe and meaningful international educational opportunities; many desire assurance that their earned degrees will prepare them for the future implications of globalization.

Great challenges and tremendous opportunities in the field of health care have also been created by globalization. We are experiencing an increased permeability of our borders to travel-related illnesses and to diseases thought to have been eradicated in the United States of America and we fear that our public health infrastructure may be ill-prepared for intentional or unintentional introduction of biologic agents capable of creating epidemic illness. Conversely, international colleagues’ experiences, approaches, and knowledge have never been more readily accessible.

As borders between countries, information, and economies lose their traditional relevance, the need to understand and interact with international health care colleagues and policy makers grows. In an accelerating fashion, health policy decisions and evidence-based experience in medical, surgical, manual, and other health care fields outside our national borders directly impact our own internal patient populations and the practices of our osteopathic medical graduates. The impact on health care providers, educators, researchers, and policy makers brought about by such globalization necessitates coordinated decisions based upon a clear understanding of the global picture.

The need to think and act globally to assure the quality of health care practitioners – both osteopathic and allopathic – crossing borders (e.g., between Canada and the United States or within the European Union) must embrace responsible health policy considerations as it impacts access, safety, and portability. To this end, the AOA expanded its involvement with international groups and organizations and has encouraged ambassadors from the AOA or its practice affiliates to
interact with global health care entities such as the the Fédération Internationale de Médecine Manuelle, the Osteopathic International Alliance (OIA), and the World Health Organization through the OIA, and any other international organization deemed appropriate. These interactions have resulted in numerous processes to evaluate international curricula and educational standards and prompted efforts to define and develop uniform educational and/or licensure standards relative to osteopathic medicine. Such involvement has greatly expanded the perspective and understanding of numerous health policy makers around the globe and within the AOA membership itself concerning the osteopathic profession. In particular, these efforts have raised awareness of the global role of the AOA in health care policies and principles and its commitment to distinctive contributions to high quality medical care (health systems change, access, reliability, and patient protections).

Globalization is affecting the osteopathic profession, but it is not solely an economic or trade phenomenon; it is a convergence of cultures. It leads inevitably to continuous cultural evolution and an increase in quality standards. The processes of which should be undertaken with humility and an understanding of the national and professional cultures involved.

INTRODUCTION

The osteopathic medical profession originated in rural America in 1892. Almost immediately graduates emigrated to other countries. Historically, national boundaries and practice rights served to create cultural divergence within the osteopathic profession. As a consequence, the osteopathic philosophy, science, and art have evolved differently over time on numerous continents with varying impact on health care delivery in each country. In some countries, the philosophy, science and art of osteopathy needed to operate in a limited spectrum-of-practice setting, linked or not to parallel standards of medical diagnosis and treatment. In some countries, selected elements of the osteopathic culture were transferred in post-graduate or specialty training settings to full spectrum-of-practice physicians simply as “manual medicine” skills. In yet other countries, these full-spectrum manual medicine physicians seek to expand their understanding of the osteopathic philosophy, science and art. As a consequence of divergence, the recognition of what it means to practice “osteopathically” has become blurred and confusion abounds in both public and professional settings. This confusion complicates efforts by the profession to convey the contribution of knowledge and service they are committed to make in promoting health and fighting disease.

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2 “As we strive to enhance the internationalization of the health professions education and the development of high standards of practice, we must take care to do so with humility. We must recognize that other nations expect cooperation and collaboration rather than an imposition of standards and procedures. We must be willing to learn from others, to change our procedures to adapt to their needs, and to adopt what they contribute.

We must tread lightly. Although we have a long history of excellent higher education, we do not have a monopoly on quality. In fact, for more than a century, acquiring at least part of one’s education in Europe was highly sought after. It is considered by many in the United States to be evidence of quality. We must never forget that many contributions to professional practice, education, scientific knowledge, and technology come to us from other countries.” -- O’Brien Richard L. Globalization: opportunities for international standards. In Osterweis M, Holmes DE (editors): Global Dimensions of Domestic Health Issues (2000), Washington DC: Association of Academic Health Centers, pp 133-146.
Cultural divergence in health care arenas is now being replaced by convergence. This is a direct consequence of increasing transportation, communication, and information exchange and is seen in the proliferation of national organizations committed to establishing global vision statements and strategic plans that include their international role. Such collaboration is also seen from stakeholders within the osteopathic arena. A number of international organizations, including the Osteopathic International Alliance, and the European Register of Osteopathic Physicians, have recently been constituted to address similar issues.

BIOM is currently charged with reporting to the AOA Board of Trustees. Its current mission is stated as follows:

The mission of the Bureau on International Osteopathic Medicine (BIOM) is to promote the highest standards of osteopathic medical education and practice throughout the world. The BIOM’s vision is acceptance of osteopathic medicine as a complete system of medical care throughout the world.

The Bureau will do this by providing organizational leadership that promotes the highest standards of osteopathic medical education and practice throughout the world and facilitates positive interactions between the AOA, AOA affiliates, and international healthcare organizations. The purpose is to ensure the continued contribution of the American model of osteopathic medicine in the United States (U.S.) and internationally.

The International Bureau seeks to facilitate those public and professional interactions, which increase the understanding and advancement of osteopathic medicine as a complete system of medical care. The BIOM will promote the osteopathic philosophy that combines the needs of the patient with the current practice of medicine, surgery, and obstetrics, emphasizes the interrelationships between structure, function, and provides an appreciation of the body’s ability to heal itself.

This third White Paper combines and updates the first two White Papers, and represents the dramatic and rapid changes that have occurred as a consequence of globalization, outreach by the AOA and its members, and international events. The structure and function of the third International White Paper focus on the following topics related to international interactions and directions by the AOA and its members:

1. AOA Official Interactions
2. Interactions with International Governmental Officials and/or Health/Medical Regulatory Bodies
3. Communication
4. Identity
5. Politics & Diplomacy
6. Research & Education
7. Interactions with International Colleges of Medicine or Osteopathy or Their Graduates
8. American Osteopathic Rights in International Settings
9. International “Osteopathic” Rights in the United States
10. International Membership in the AOA
11. Service
12. Resources
The periodically updated addendum, *Potentially Significant International Organizations & Groups*, identifies organizations and groups within and outside the United States with which the AOA and its members may have contact or correspondence in discussing international osteopathic curricula, accreditation, certification, and/or licensure.

1. AOA OFFICIAL INTERACTIONS

The AOA itself shall be directly represented only by those it has authorized to do so. No interactions by an unauthorized individual, college, specialty organization, or institution should imply a specific AOA status or endorsement, nor be allowed to be represented as such.

The AOA Bureau of International Osteopathic Medicine (BIOM) is charged with informing and educating AOA leadership and representatives; gathering, investigating, and recommending policy relative to international osteopathic medical education and affairs; maintaining information used in training international ambassadors and representatives; and serving as a repository for information related to the aforementioned activities. AOA members and affiliates are encouraged to contact BIOM and its members and staff with information, recommendations, international contacts, and potential directions for the AOA in meeting its international agenda.

2. INTERACTIONS WITH GOVERNMENTAL OFFICIALS AND/OR HEALTH/MEDICAL REGULATORY BODIES

Interactions carried on by individuals, colleges, specialty organizations or other U.S. osteopathic institutions to discuss osteopathic medicine should be accomplished in a careful, professional, and ethical manner, accurately representing the American model of osteopathic medicine. Information detailing the international contact name, preferably including telephone, fax, and e-mail information, title and synopsis of discussion, may be sent to the AOA Division of International Affairs, 142 East Ontario, Chicago, Illinois 60611, Phone (312) 202-8000. While it is not always possible to do so, an advanced call to the AOA may be beneficial and is encouraged.

In dealing with international governmental officials, or health and medical regulatory bodies, the following points may be conveyed:

1. The AOA seeks to better understand the status of international medical communities in the areas of education, research, and health care delivery.
2. The AOA seeks to encourage international recognition, understanding, and acceptance of the American DO degree.
3. The AOA seeks to advance international recognition and value for osteopathic philosophy, as well as its practice and educational standards.
4. The AOA will actively offer assistance and guidance, upon request, to nations or official organizations wishing to provide for the licensure/registration and practice rights of osteopathic physicians educated in colleges of osteopathic medicine accredited by the AOA Commission on Osteopathic College Accreditation (COCA).
5. BIOM will, upon request, assist COCA regarding the legitimate authorities or programs from other countries in the development of colleges of osteopathic medicine or osteopathic graduate
medical education programs when such entities clearly demonstrate the capacity to be accredited by COCA.

3. COMMUNICATION

The AOA recognizes the need for accurate and ethical communication in relation to international issues, particularly in light of differences in language and culture.

Information into and out of the United States is capable of both supporting a rapidly growing evidence-base for wise health care decisions and of confounding appropriate decisions with misinformation. The AOA is dedicated to providing accurate information related to the contributions of its members and the osteopathic approach. To this end, the following elements have been agreed upon:

1. The AOA will act as a clearinghouse for information concerning international applications of the philosophy, science, and art of osteopathy and osteopathic medicine.

2. The AOA will also contribute information to the Osteopathic International Alliance (OIA) clearinghouse so that it may also serve as a credible, reliable international source of information, and contribute to the Glossary of Osteopathic Terminology as well as interested governmental, regulatory, and Non-Governmental Organization (NGO) bodies.

3. The Bureau of International Osteopathic Medicine (BIOM) will identify persons available to translate Bureau materials into various languages, starting with French, German, and Spanish and eventually all official UN languages.

4. The AOA recognizes the efforts of the American Association of Colleges of Osteopathic Medicine (AACOM) and the Educational Council on Osteopathic Principles (ECOP) to maintain a peer-reviewed Glossary of Osteopathic Terminology and encourages an accurate translation into other languages that it might serve as a universal language reference for osteopathic and manual medicine education, research, and clinical discussions.

5. Members of the AOA will refrain from representing the AOA or its official position without the express permission of the AOA.

6. Members of the AOA are encouraged to educate the public as well as health care colleagues about the manner in which the philosophy, science, and art of osteopathic medicine are practiced in the United States of America.

7. The AOA charges BIOM to continue to plan and provide an international seminar and forum for the profession at the annual meetings to update AOA members on international issues, the activities of their colleagues, and the AOA’s progress abroad on their behalf.

4. IDENTITY

The AOA recognizes the need to identify and educate international organizations, governmental authorities, and leaders concerning the benefits of osteopathic philosophy, science, and art in promoting/maximizing health while limiting disease and dysfunction.

To this end, the following directions are supported:

1. The AOA will actively seek to provide communication and/or representation to key international bodies with the expressed intention of communicating the scope of osteopathic
philosophy and practice and the potential for the osteopathic profession to contribute to health and preventive medicine throughout the world.

2. Wherever possible, the AOA will interact with and educate key international leaders and international bodies about the osteopathic profession with the expressed intention of expanding opportunities whereby graduates of AOA-accredited schools (or the American osteopathic profession as a whole) could make positive contributions.

3. The AOA will specifically interface with the International Association of Medical Regulatory Authorities (IAMRA), International Federation of Manual Medicine (FIMM), the Osteopathic International Alliance (OIA), and others who seek to identify and contribute to areas of overlapping missions.

4. The Bureau of International Osteopathic Medicine (BIOM) and its representatives will aspire to collaborate with international colleagues and organizations to obtain unlimited medical and surgical practice rights internationally for osteopathic physicians.

5. BIOM will develop a Network Database (accessible to AOA members) of individual DOs and affiliates around the world, who are willing to assist other DO expatriates.

5. POLITICS & DIPLOMACY

The AOA embraces its unique position as representing American trained osteopathic physicians and surgeons, the largest group of osteopathic practitioners in the world and its historic link to the birthplace of the entire osteopathic profession. However, the AOA also recognizes the sovereignty of health care licensure and delivery systems in other nations as well as the evolutionary differences in osteopathic education and scope of practice that occurred when osteopathy emigrated to other countries. Above all, the AOA acknowledges the need to be geographically and culturally sensitive in interacting within the international health care arena.

To this end:

1. The American Osteopathic Association, as an organization, is dedicated to placing patients first and protecting the patient/physician relationship. This position of the AOA extends beyond U.S. borders and will serve as a template for policy relating to political and health policy considerations internationally.

2. The AOA accepts its role and ability to provide organizational leadership unifying osteopathic medical education & practice throughout the world. It maintains the AOA Bureau of International Osteopathic Medicine (BIOM) to recommend liaison and policy to this end.

3. The AOA supports the growth of the Osteopathic International Alliance (OIA) as an umbrella organization of internationally governmentally recognized organizations made up of osteopaths, osteopathic physicians and surgeons, and/or manual medicine physicians who value and promote the osteopathic approach.

4. The AOA will continue to contribute to the development of qualified AOA International Ambassadors to serve as knowledgeable and effective liaisons for the osteopathic medical profession in international affairs and policy.

5. The AOA will maintain & enhance contacts with international organizations including, but not limited to the Canadian Osteopathic Association (COA), Fédération Internationale de Médecine Manuelle (FIMM)), International Association of Medical Regulatory Authorities (IAMRA), and any other international organization deemed appropriate.
6. The AOA will work with the Federation of Medical Regulatory Authorities of Canada [FMRAC], Federation of State Medical Boards [FSMB], and International Association of Medical Regulating Authorities [IAMRA] so as to reach as many ministries of health as possible.

7. The AOA will develop and maintain affiliates outside the U.S.A. who qualify for appropriate representation in the AOA House of Delegates.

6. RESEARCH & EDUCATION

The AOA is committed to contributing to the expansion, dissemination, application, and integration of the evidence-base for health care practices generally, including the field of manual/neuromusculoskeletal medicine that constitutes one of the distinctive cornerstones of the osteopathic profession.

To this end, the following directions are supported:

1. Wherever possible, the AOA will encourage collaboration and/or wide international dissemination of the findings of research related to the promotion of health including palpatory diagnosis and manual medicine approaches; the relevance of somatic dysfunction and its reduction in affecting health promotion and disease prevention; and outcomes research documenting patient satisfaction and the clinical safety, cost-effectiveness, and efficacy of osteopathic clinical approaches (or manual-medicine integrative approaches).

2. The AOA will delineate pathways by which members of the AOA and representatives of the AOA Council on Research, Bureau of Osteopathic Research and Public Health (BORPH) and/or AACOM may effectively interact with international medical and osteopathic institutions and organizations, through the OIA, to plan, foster, and/or participate in collaborative research advancing osteopathic and/or neuromusculoskeletal medicine.

3. The AOA will seek to identify and collaborate with institutions having the potential and desire to develop osteopathic medical education that would, at a minimum, parallel the educational standards adopted by the AOA. Furthermore, it will charge BIOM to encourage, promote & offer assistance to the AOA Commission on Osteopathic College Accreditation (COCA) in any way necessary.

4. The AOA will delineate the pathway or pathways by which representatives of the AOA, AOA specialty colleges, BOE, and/or COCA may (upon request) effectively and responsibly consult with/for international medical and osteopathic institutions and organizations to evaluate, improve, and/or coordinate educational standards and evaluation between countries and/or educational bodies.

5. The AOA is a resource to AACOM, Educational Council on Osteopathic Principles (ECOP), and other organizations for information on international research and education.

6. The AOA will delineate the pathway or pathways by which an international educational institution might apply for and attain appropriate accreditation in order to graduate osteopathic physicians completely versed in the osteopathic philosophy, science, and art. Unless otherwise assigned, BIOM might be charged to evaluate applications with respect to the international implications, risks, and benefits of each application relative to the AOA’s international strategic plan.

7. The AOA will encourage specialty colleges and colleges of osteopathic medicine to develop member training opportunities outside the U.S.A., including but not limited to undergraduate/post-graduate fellowships, CME programs, and international exchanges.
8. Professional seminars, lectures, workshops and other educational meetings concerning osteopathic medicine or surgery should promote understanding of health care content generally within the scope of practice or education of those attending the course as should osteopathic graduate medical education (OGME).

9. To ensure that the highest quality of osteopathic medical care is made available to all Americans, the AOA acknowledges the value of international contributions made to the field, either individually, by groups, or by organizations and will record these findings in a Network Database. This Database will have available the current international research, activities, and contributions of osteopathic and manual medicine groups to health care. This Network Database will, where possible, maintain a record of cost-efficacy analyses and outcomes of these approaches.

10. Communications and written materials should clearly state that education about the philosophy, science, and/or art of osteopathy or osteopathic medicine does not alone create an osteopathic practitioner or entitle an attendee to claim such.

7. INTERACTIONS WITH INTERNATIONAL COLLEGES OF MEDICINE OR OSTEOPATHY OR THEIR GRADUATES

Interactions by individuals, colleges of osteopathic medicine, osteopathic specialty organizations or other U.S. osteopathic institutions to advance the understanding of the science, art, and practice of osteopathic medicine in the United States, are encouraged at international colleges of medicine or osteopathy, as well as with their students and graduates.

To this end:

1. Such interactions should always be accomplished in a careful, professional, and ethical manner, accurately representing the American model of osteopathic medicine. Lectures, discussions, and/or demonstrations are typically appropriate for international audiences and should be used responsibly to advance understanding. Members of the AOA, its affiliates, and AOA accredited institutions and programs, should refrain from the hands-on teaching of osteopathic manipulative treatment, injection, diagnostic or therapeutic surgical and/or diagnostic or therapeutic invasive procedures to individuals who do not, or will not upon graduation, have the complete foundation to responsibly master or possess the legitimate scope of practice to apply said skills or procedures.

2. With regard to continuing medical education (CME) at, or organized by, international colleges of medicine or osteopathy, it should be made clear that the AOA recognizes continuing medical education programs in other countries only when such programs meet the continuing medical education requirements of the AOA. Only the AOA shall determine when a CME program qualifies for AOA recognition.

3. Programs, including CME and Continuing Professional Development (CPD) programs, organized by U.S. osteopathic organizations to advance the understanding of the science, art, and/or practice of osteopathic medicine which might include students or graduates of international colleges of medicine or osteopathy, must clearly indicate to these individuals that they may not falsely advertise their participation in said program. International osteopathic ethics limit claims, written or verbal, regarding participation in such programs, to statements of attendance at a specific educational or scientific meeting. U.S. osteopathic physicians who teach in such programs shall make this clear to both the organizers and participants.
8. AMERICAN OSTEOPATHIC RIGHTS IN INTERNATIONAL SETTINGS

The AOA Commission on Osteopathic College Accreditation (COCA) is recognized in the United States by the Federal government and its Department of Education, Department of Health and Human Services, and related governmental entities, as the official accrediting agency for all U.S. colleges of osteopathic medicine. The AOA is the body that recognizes and approves osteopathic graduate medical education and continuing medical education. The AOA, through its Bureau for Osteopathic Specialists, is the body responsible for the specialty certification of osteopathic physicians.

To this end:

1. The degree, Doctor of Osteopathy (DO), or Doctor of Osteopathic Medicine (DO), when granted by a COCA-accredited college of osteopathic medicine, is considered in all 50 states, the District of Columbia, and territories, to be eligible for full medical licensure, equal in all rights, privileges, and responsibilities as those physicians holding the degree Doctor of Medicine (MD).

2. In the United States, physicians with an AOA recognized DO degree may serve as physicians in all capacities and are fully reimbursed at the same level and for the same services as those with the MD degree. They may practice in state, private and governmental hospitals as well as in outpatient settings.

3. American osteopathic physicians, by virtue of their education and AOA certification(s), have valuable skills to offer patients wherever they may be accorded the right and privilege to practice their healing arts.

4. The AOA has no jurisdiction internationally, but is willing and anxious to assist members of the AOA in representing their credentials to government agencies, departments of health, or other professional institutions.

5. As officers in the Medical Corps of the U.S. Uniformed Services, osteopathic physicians have for many years served on military bases around the world. Several osteopathic physicians hold, or have held, high-ranking positions, such as the Surgeon General of the United States Army and the Assistant Secretary of Defense for Health Affairs.

6. American osteopathic physicians and colleges are active in international humanitarian and missionary work in numerous countries. DOCARE International is an AOA affiliated osteopathic organization that coordinates and delivers humanitarian work. Osteopathic clinicians are also providing international humanitarian and missionary care through their churches, communities, specialty colleges, service and other organizations.

9. INTERNATIONAL "OSTEOPATHIC" RIGHTS IN THE UNITED STATES

It is the unwavering position of the AOA that the only type of licensure for DOs in the United States is one reflecting a full scope of medical practice. For all licensure as a DO in every state in the United States, the DO must be a graduate of a COCA-accredited college of osteopathic medicine. No state issues a "limited license" to any practitioner, either an American citizen or an international citizen, wishing to practice osteopathy or osteopathic medicine in the United States.

To that end:
1. Where state laws permit, internationally-trained manual therapeutic practitioners, or "non-physician osteopaths," may observe or even work in a physician's office. Such individuals may only interact with patients, however, to the extent allowed by the statutes of that state; while under the supervision of an attending physician, or his/her staff. In no case may the international practitioner attempt to represent his or her degree as equal to an American DO degree. Likewise, the interaction with a client may never be represented as, or implied to be, an osteopathic examination or treatment.

2. "Non-physician osteopaths," or those practicing manual therapy may, within specific guidelines, participate in U.S. osteopathic educational or research activities organized by AOA members, colleges, specialty colleges, institution, or other affiliates. AOA guidelines are specific to the situation. For example, the "non-physician osteopath", or manual therapist, may be employed under the supervision of an American DO to assist in teaching osteopathic manipulative treatment (OMT) techniques at an osteopathic college or in a CME program. In such cases, however, it must be clearly stated to students or attendees that said individual is not a physician. Neither may an internationally trained "non-physician osteopath", or manual therapist, be counted amongst those osteopathic medical faculty members required for AOA-approved CME credit.

3. International Doctors of Medicine (MD) who have earned a "diploma or specialty in manual medicine (osteopathic)" or its equivalent in their medical pre-doctoral or post-doctoral training, may not represent themselves in the United States as osteopathic physicians.

4. Those international MD/DO physicians whose DO was granted by a non-AOA accredited international osteopathic college may not represent themselves as osteopathic practitioners in the United States, nor may they use their internationally obtained DO diploma or degree in the United States in any professional capacity. To advertise to the public that they are DOs is a violation of the state medical licensing laws, rules and regulations in the United States, as well as a violation of the AOA Code of Ethics.

5. International MD or MD/DO practitioners may or may not be eligible to sit for allopathic licensure in the United States. Such a decision is outside the purview of the AOA. These physicians may not however represent themselves as osteopathic physicians, DOs, in the United States as there is no provision for sitting for an American osteopathic test, or obtaining an osteopathic medical license except by graduation with a “DO” degree from an AOA-accredited college of osteopathic medicine.

6. International institutions, organizations, or programs seeking AOA accreditation or recognition must meet all AOA guidelines for the appropriate and pertinent osteopathic medical programs.

10. INTERNATIONAL MEMBERSHIP IN THE AOA

American educated and trained DOs living and/or practicing abroad may join the American Osteopathic Association under the same guidelines as those osteopathic physicians living and/or practicing in the United States. Costs of AOA membership are specified in annual publications of the AOA and may reflect an additional cost for processing and mailing internationally. International MD and MD/DO practitioners living and/or practicing abroad or those who have moved to the United States from abroad are eligible for "AOA International Physician Membership" status.

To this end:
1. Membership requires completion and acceptance of the "International Physician Application" of the AOA, along with a letter of recommendation from a member of the AOA who can attest to the ethical character and professional qualifications of the applicant. This category is only open to those international physicians with a license for full-scope medical practice as a physician in their country of citizenship.

2. The membership category "International Physician Membership" is a non-voting category designed to identify individuals wishing to receive educational, research, and similar pertinent information from the AOA. Such members may not hold office in the AOA or any of its affiliate organizations. Membership in this category may not be publicized or claimed to represent any level of professional qualification; nor may such membership be used to imply additional skills, knowledge, or other status beyond that for which they qualify.

11. SERVICE

The AOA represents fully licensed osteopathic physicians and osteopathic medical students in the United States who are dedicated to promoting health and treating disease. Osteopathic physicians' contributions in primary care and the distinctive osteopathic philosophy are widely recognized by health policy makers in the United States and by leaders in rural and underserved areas. The AOA believes that these attributes could contribute to the betterment of health and health care internationally.

To this end:

1. The AOA will continue aiding American DOs in humanitarian and mission work by facilitating international governmental permission to bring in medical teams and supplies and to provide osteopathic medical and surgical care.

2. The AOA will encourage international recognition of AOA-accredited DOs by developing a systematic method of contacting the various ministries of health (MOH) to apprise them of the unique education, high standards and full practice rights of physicians of osteopathic medicine thus accredited.

3. The BIOM will continue collaborating with the OIA and other international organizations to facilitate humanitarian and mission work.

12. RESOURCES

The AOA has committed resources to address the many acute national issues of its members in the United States, Canada and throughout the world. The AOA acknowledges that its members function in a global society and that our next generation of osteopathic physicians demonstrates significant interest in making international commitments on behalf of the profession.

To this end:

1. The AOA will conduct periodic assessments of AOA member needs and desires regarding internationally-oriented member services; and prioritize input from its student and post-graduate representatives.

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3 The term “fully licensed” represents both the concept of an unlimited license issued by the state to practice all aspects of the healing art and includes the scope of the term “registered” more commonly used outside of the United States.
2. The AOA will prioritize contacts and develop criteria for deciding what countries &
organizations should be the focus of AOA activity.

3. The AOA will charge BIOM to recommend policies and procedures on international
osteopathic medicine to the Bureau of Osteopathic Education & the AOA Board of Trustees.

4. The AOA will enhance and maintain electronic and Internet capabilities to allow for easy access
of international network database information.
ADDENDUM: Selected U.S. and International Organizations & Groups

This addendum lists selected organizations and groups which the AOA either maintains active interactions with or are/may be potentially significant partners in conducting the functions and achieving the missions of the AOA, particularly as related to international issues. This list is not complete but will continue to be expanded as other organizations and groups are identified.

Note that the Chart below is arranged by the abbreviation most commonly used to identify the group or organization.

Organizational abbreviations & names, location and scope of influence:

<table>
<thead>
<tr>
<th>ABBREVIATION</th>
<th>OFFICIAL NAME &amp; WEBSITE</th>
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<tbody>
<tr>
<td>AACOM</td>
<td>American Association of Colleges of Osteopathic Medicine</td>
</tr>
<tr>
<td>AAMC</td>
<td>Association of American Medical Colleges</td>
</tr>
<tr>
<td>AAO</td>
<td>American Academy of Osteopathy</td>
</tr>
<tr>
<td>AAOE</td>
<td>American Association of Osteopathic Examiners</td>
</tr>
<tr>
<td>AAOM</td>
<td>American Association of Orthopaedic Medicine</td>
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<tr>
<td>ACCME</td>
<td>Accreditation Council for Continuing Medical Education</td>
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<tr>
<td>ACGME</td>
<td>Accreditation Council for Graduate Medical Education</td>
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<tr>
<td>ACOFP</td>
<td>American College of Osteopathic Family Physicians</td>
</tr>
<tr>
<td>AFMM</td>
<td>Australian Association of Musculoskeletal Medicine</td>
</tr>
<tr>
<td>AFO</td>
<td>Akademie für Osteopathie/Academy for Osteopathy</td>
</tr>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
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<tr>
<td>AMSA</td>
<td>American Medical Student Association</td>
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<tr>
<td>AOA-US</td>
<td>American Osteopathic Association</td>
</tr>
<tr>
<td>AOA-AU</td>
<td>Australian Osteopathic Association</td>
</tr>
<tr>
<td>AOA-FR</td>
<td>Association des Ostéopathes d’Anjou/Anjou Association of Osteopaths</td>
</tr>
<tr>
<td>APO</td>
<td>Associacao de Portuguese de Osteopatas/Portugese Association of Osteopaths</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Name</td>
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<tr>
<td>AROP</td>
<td>Associação e Registo dos Osteopatas de Portugal/Association and Registry of Portuguese Osteopaths</td>
</tr>
<tr>
<td>BAO</td>
<td>Bundes Arbeitsgemeinschaft Osteopathie/Federal Working Group on Osteopathy</td>
</tr>
<tr>
<td>BCOA</td>
<td>British Columbia Osteopathic Association of Canada</td>
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<tr>
<td>BIMM</td>
<td>British Institute of Musculoskeletal Medicine</td>
</tr>
<tr>
<td>CaRMS</td>
<td>Canadian Resident Matching Service</td>
</tr>
<tr>
<td>CBA</td>
<td>Chiropractic Board of Australia</td>
</tr>
<tr>
<td>CEESO-Paris</td>
<td>Centre Européen d’Enseignement Supérieur de l’Osteopathie – Paris/European Center for Higher Education in Osteopathy</td>
</tr>
<tr>
<td>CFPC</td>
<td>College of Family Physicians of Canada</td>
</tr>
<tr>
<td>CPSO</td>
<td>College of Physicians and Surgeons of Ontario</td>
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<tr>
<td>COA</td>
<td>Canadian Osteopathic Association</td>
</tr>
<tr>
<td>COCA-AOA</td>
<td>Commission on Osteopathic College Accreditation</td>
</tr>
<tr>
<td>COCA-AU</td>
<td>Chiropractic &amp; Osteopathic College of Australasia</td>
</tr>
<tr>
<td>COME</td>
<td>Center for Osteopathic Medicine Collaboration</td>
</tr>
<tr>
<td>DAAO</td>
<td>Deutsch-Amerikanischen Akademie für Osteopathie/German-American Academy of Osteopathy</td>
</tr>
<tr>
<td>DGCO</td>
<td>Deutsche Gesellschaft für Chirotherapie und Osteopathie/German Society for Chirotherapy and Osteopathy</td>
</tr>
<tr>
<td>DGMM</td>
<td>Deutsche Gesellschaft für Manuelle Medizin/German Society for Manual Medicine</td>
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<tr>
<td>DGOM</td>
<td>Deutsche Gesellschaft für Osteopathische Medizin/German Society for Osteopathic Medicine</td>
</tr>
<tr>
<td>DOCARE</td>
<td>DOCARE International</td>
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<td>International</td>
<td><a href="http://www.docareintl.org">www.docareintl.org</a></td>
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<tr>
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</tr>
</tbody>
</table>
| MSF           | Medecins Sans Frontier/Doctors Without Borders  
www.doctorswithoutborders.org |
| DVOM          | Deutscher Verband fur Osteopathische Medizin/German Association for Osteopathic Medicine  
http://www.dvom.de/ |
| ECFMG         | Educational Commission for Foreign Medical Graduates  
www.ecfmg.org |
| ECOP          | Educational Council on Osteopathic Principles  
https://www.aacom.org/ome/aacom-councils-and-groups/aacom-councils/educational-council-on-osteopathic-principles |
| EFFO          | European Federation & Forum of Osteopaths  
https://www.effo.eu/ |
| EROP          | European Register of Osteopathic Physicians  
https://www.osteointernational.uk/networks/european-register-of-osteopathic-physicians/ |
| FAIMER        | Foundation for the Advancement of International Medical Education and Research  
http://www.faimer.org/index.html |
| FeSIO         | Federazione Sindacala Italiana Osteopati/Italian Federation of Osteopaths  
http://www.fesios.it/ |
| FEMMO         | Fédération Francophone des Enseignements de Médecine Manuelle-Ostéopathie/Federation of Francophone Osteopathic Manual Medicine Education – Umbrella organization made up of 21 French, Belgian, and Swiss groups  
http://www.femmo.eu/ |
| FIMM          | Fédération Internationale de Médecine Manuelle/International Federation of Manual Medicine  
www.fimm-online.com |
| FMRAC         | Federation of Medical Regulatory Authorities of Canada  
http://www.fmrac.ca |
| FSMB          | Federation of State Medical Boards  
www.fsmb.org/ |
| FSO-SVO       | Fédération Suisse des Ostéopathes – Schweizer Verband der Osteopathen/ Swiss Federation of Osteopaths  
https://www.fso-svo.ch/ |
| GHC           | Global Health Council  
www.globalhealth.org/ |
| GHWN          | Global Health Workforce Network  
https://www.who.int/hrh/network/en/ |
| GMC           | General Medical Council of the UK  
http://www.gmc-uk.org/ |
| GosC          | General Osteopathic Council (U.K.)  
http://www.osteopathy.org.uk/ |
| HHI           | Heart to Heart International  
http://www.hearttoheart.org/ |
| IAMRA          | International Association of Medical Regulating Authorities  
| IAO           | International Academy of Osteopathy  
| IFMSA         | International Federation of Medical Students’ Associations  
| IMC           | International Medical Corps  
|               | [https://internationalmedicalcorps.org/](https://internationalmedicalcorps.org/) |
| JOF           | Japan Osteopathic Federation  
|               | [www.osteopathy.gr.jp](http://www.osteopathy.gr.jp) |
| LCME          | Liaison Committee on Medical Education  
| MCC           | Medical Council of Canada  
|               | [http://www.mcc.ca/](http://www.mcc.ca/) |
| MCNZ          | Medical Council of New Zealand  
| NAO           | Norwegian Association of Osteopathy  
|               | [www.osteopati.org](http://www.osteopati.org) |
| NBOME         | National Board of Osteopathic Medical Examiners  
|               | [www.nbome.org/](http://www.nbome.org/) |
| NZAMSM        | New Zealand Association of Musculoskeletal Medicine  
|               | [http://www.musculoskeletal.co.nz](http://www.musculoskeletal.co.nz) |
| OCI           | Osteopathic Council of Ireland  
|               | [https://www.osteopathy.ie/](https://www.osteopathy.ie/) |
| ONZ           | Osteopathic Council of New Zealand Osteopathic  
|               | [https://www.osteopathiccouncil.org.nz/](https://www.osteopathiccouncil.org.nz/) |
| OAMM          | Österreichische Ärztegesellschaft für Manuelle Medizin (ÖÄMM)/Austrian Association for Manual Medicine  
|               | [http://www.manuellemedizin.org/](http://www.manuellemedizin.org/) |
| OdF           | Ostéos de France/Osteopaths of France  
|               | [http://www.osteos.net/](http://www.osteos.net/) |
| OGO           | Österreichische Gesellschaft für Osteopathie/Austrian Society for Osteopathy  
|               | [www.oegso.org](http://www.oegso.org) |
| OHHPF         | Osteopathic Heritage Health Policy Fellowship  
|               | [https://www.aacom.org/reports-programs-initiatives/leadership-institute/osteopathic-health-policy-fellowship](https://www.aacom.org/reports-programs-initiatives/leadership-institute/osteopathic-health-policy-fellowship) |
| OIA           | Osteopathic International Alliance  
|               | [www.oialliance.org/](http://www.oialliance.org/) |
| OOA           | Ontario Osteopathy Association  
|               | [https://ontarioosteopathy.com/](https://ontarioosteopathy.com/) |
| OCNSW         | Osteopathic Council of New South Wales  
| PFH           | Physicians for Humanity  
|               | [www.physiciansforhumanity.org](http://www.physiciansforhumanity.org) |
| RCPSC         | Royal College of Physicians and Surgeons of Canada  
<p>|               | <a href="http://rcpsc.medical.org/main_e.php">http://rcpsc.medical.org/main_e.php</a> |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROD</td>
<td>Register der Traditionellen Osteopathen in Deutschland/Register of Traditional Osteopaths of Germany</td>
<td><a href="https://www.r-o-d.info/">https://www.r-o-d.info/</a></td>
</tr>
<tr>
<td>ROE</td>
<td>Registro de Osteópatas de Espana/Spanish Registry of Osteopaths</td>
<td><a href="http://www.osteopatas.org">www.osteopatas.org</a></td>
</tr>
<tr>
<td>ROF</td>
<td>Registre des Ostéopathes de France/French Registry of Osteopaths</td>
<td><a href="http://www.osteopathie.org">www.osteopathie.org</a></td>
</tr>
<tr>
<td>ROI</td>
<td>Registro degli Osteopati d’Italia/Italian Registry of Osteopaths</td>
<td><a href="http://www.roi.it">http://www.roi.it</a></td>
</tr>
<tr>
<td>ROR</td>
<td>Register of Osteopaths of Russia</td>
<td><a href="http://www.osteopathy.ru">www.osteopathy.ru</a></td>
</tr>
<tr>
<td>SAGOM</td>
<td>Swiss Society of Osteopathic Medicine</td>
<td><a href="http://www.sagom.ch">http://www.sagom.ch</a></td>
</tr>
<tr>
<td>SFDO</td>
<td>Syndicat Français Des Ostéopathes/French Syndicate of Osteopaths</td>
<td><a href="http://sfdo.info">sfdo.info</a></td>
</tr>
<tr>
<td>SOF</td>
<td>Svenska Osteopatförbundet (Sweden)</td>
<td><a href="http://www.osteopatforbundet.se">www.osteopatforbundet.se</a></td>
</tr>
<tr>
<td>UBO/BUO</td>
<td>Union Belge des Ostéopathes/Belgian Union of Osteopaths</td>
<td></td>
</tr>
<tr>
<td>Unitec</td>
<td>Unitec School of New Zealand</td>
<td><a href="http://www.unitec.ac.nz/">www.unitec.ac.nz/</a></td>
</tr>
<tr>
<td>USMLE</td>
<td>United States Medical Licensing Exam</td>
<td><a href="http://www.usmle.org/">www.usmle.org/</a></td>
</tr>
<tr>
<td>VOD</td>
<td>German Osteopathic Association</td>
<td><a href="http://www.osteopathie.de">www.osteopathie.de</a></td>
</tr>
<tr>
<td>Wonca</td>
<td>World Organization of Family Doctors</td>
<td><a href="http://www.globalfamilydoctor.com">www.globalfamilydoctor.com</a></td>
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<tr>
<td>WDMS</td>
<td>World Directory of Medical Schools</td>
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<td></td>
<td><a href="https://www.wdoms.org/">https://www.wdoms.org/</a></td>
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</table>
WHEREAS, the American Osteopathic Association Board of Trustees approved a White Paper On Guidelines for International Electives and Cultural Competencies For Osteopathic Physicians-in-Training (2011) as a resource for osteopathic physicians-in-training and osteopathic training institutions and to encourage educational standardization of key component elements for international and cultural enrichment programs completed by those institutions, in order to foster safety, maximize educational outcomes and positively impact outcomes for osteopathic physicians-in-training, and the attached White Paper is an update of the previous Paper; now, therefore, be it

RESOLVED, that the AOA Board of Trustees approve the attached White Paper as the official document of the AOA’s Bureau on International Osteopathic Medicine.

ACTION TAKEN _____________________

DATE ______________________________
Bureau on International Osteopathic Medical Education and Affairs

WHITE PAPER
On
Guidelines for International Electives and Cultural Competencies
For Osteopathic Physicians-in-Training

White Paper Committee:
Reza Nassiri, DSc, Chair
James Cole, DO
Michael L. Kuchera, DO
Nora Burns, OMS
Raul Garcia, DO, Consultant
Peter Adler-Michaelson, DO, Ex-Officio Member
Joshua Kerr, MA, Secretary

The American Osteopathic Association (AOA) recognizes the significant impact of culturally diverse perspectives, values, beliefs, traditions, and customs upon health care choices, health policy, and actual delivery of health care. It also appreciates that osteopathic physicians-in-training often gain valuable insights by participating in required or elective rotations in international or culturally-focused U.S. sites. Therefore, the AOA recommends development and implementation of a core “cultural competency” curriculum which would serve to meet the challenges of cross-cultural issues and osteopathic care for culturally-diverse groups in the United States. Furthermore, it recommends standardization of certain expectations for international clinical and/or research electives involving osteopathic physicians-in-training (students, interns and residents).

To facilitate safe, appropriate and meaningful expectations for such a curriculum and for international rotations, it is important that information gathering, collaboration and cooperative ventures by osteopathic institutions and representative bodies (including the American Association of Colleges of Osteopathic Medicine [AACOM] and individual colleges of osteopathic medicine [COM]) be conducted in a manner compatible with the AOA’s educational and ethical standards. Furthermore, partnerships with collaborating institutions, when possible, should be based upon fostering mutual respect and mutual benefit, sharing information and resources, and minimizing the burden on host institutions -- especially while working in Least Developed Countries (LDC).

To these ends, the AOA has developed this White Paper. Its suggestions and guidelines will hopefully enable osteopathic medical students, as well as interns and residents, to experience quality clinical clerkships both outside and across the United States while developing competencies in delivering care for patients of diverse cultural, ethnic and religious backgrounds. Equally important, the AOA desires that osteopathic physicians-in-training engaging in clinical electives in international or culturally-sensitive sites may informally yet appropriately serve as the ambassadors of the “profession” and propagate a better understanding of the American model of osteopathic education and care.

HISTORY & PURPOSE
In dealing with various international issues, the AOA has sought and continues to seek input and recommendations from its Bureau on International Osteopathic Medical Education and Affairs (BIOMEA) since formed as a Council in 1998. Furthermore, BIOMEA interacts directly with the AOA Board of Trustees to formulate and issue pertinent “White Papers” as informational pieces to
describe the scope, direction, and activity of the AOA in the international arena. Topical “White Papers” also serve AOA leadership by providing pertinent background material for focused, informed discussions leading to future decisions or policy.

In 2009, BIOMEA recommended the development of and approval of a White Paper on Guidelines for Standardization of International Clinical Clerkship and Cultural Competency for COM Students. Recognizing the applicability to interns and residents as well, this White Paper focuses on pertinent educational and logistical issues of preparing osteopathic physicians-in-training for the challenges of their clinical electives (in international and culturally-sensitive sites). It also emphasizes the ethical interactions between components of U.S. COMs, international partners, and culturally-diverse communities in delivering such quality clinical clerkships consistent with the AACOM and AOA educational standards. Topics included:

1. Development of effective guidelines for clinical clerkship curricula in international and culturally-diverse sites
2. Student, preceptor, and curricular evaluation of electives in international and culturally diverse sites
3. Pre- and post- international departure orientation concerns and needs
4. Immunizations and prophylaxis
5. Travel documents and insurance
6. Travel advisory alert and risk issues
7. Language issues in international and culturally-diverse sites
8. Ethical issues related to clinical and research electives
9. Representation of the U.S. osteopathic profession
10. Recommended core “cultural competency” curricular components towards understanding culture and customs of host countries and culturally-diverse sites

PREAMBLE
International health experiences (or those obtained in certain enclaves\(^1\) within the United States) can broaden a person’s perspective and provide a better understanding of the effect of health and illness on individuals and their culture. Such experiences have been shown to increase interest in global public health and primary care medicine for medical students and residents. For osteopathic physicians-in-training these experiences provide an opportunity not only to choose a career in international health and provide care to the underserved, but also to educate the global health community about the philosophy and practice of U.S. osteopathic medicine. Participation in an international rotation may also help osteopathic physicians-in-training to better understand opportunities and limitations related to the practice of osteopathic medicine generally and of manual treatment specifically in a given country or patient population.

Regardless of such interests, osteopathic physicians-in-training and the institutions in which they train must increasingly seek educational opportunities that are both meaningful and safe. Ideally, such “quality” educational health rotations will add to one or more of the following: knowledge of osteopathic medicine and philosophy, insights into indigenous or tropical medicine, broadening of general clinical skills, opportunity to witness or apply hands-on manual medicine practices, and acquire

\(^1\) Enclave (noun): A portion of territory within or surrounded by a larger territory whose inhabitants are culturally or ethnically distinct. (Merriam-Webster) This could include certain ethnic communities from New York to San Francisco as well as those located within several native American nations
on-site cultural or language competency in order to prepare for the many challenges of 21st century health care delivery in diverse populations.

The benefits for each COM in the United States in developing international elective and cultural competency programs are becoming increasingly obvious, based particularly upon the growing interest of their students in engaging in international clinical rotations or humanitarian aid activities, interacting with culturally diverse populations, serving U.S. communities with large ethnic populations and witnessing the impact of certain health policies, especially in impoverished regions of the world (including parts of the United States). To this end, the AOA, as an internationally-linked and culturally-sensitive organization for osteopathic medical practice, seeks to broaden its involvement with the issues of international clinical electives for COM students. It also strongly encourages each COM to consider and address the aforementioned issues to facilitate and streamline educational and logistical issues pertaining to students’ travel and hands-on clinical experience in a host country or culturally-centered U.S. community.

INTRODUCTION

The elements described in this document will be of value for participating osteopathic physicians and physicians-in-training at all stages of the continuum of osteopathic medical education, from predoctoral education through practice and continuing education. If students are participating in international or culturally-based experiences as part of their education, i.e. “for credit”, then these experiences would also need to satisfy any requirements of the respective AOA-recognized accrediting agency or approving committee.2

Research indicates that international health experiences have positive educational outcomes, including increasing the likelihood of choosing a primary care career3 and interest in serving underserved populations in the United States and abroad. The offering of such experiences can be attractive to applicants and can provide a wide range of clinical and cultural experiences for students and residents. In a survey conducted by BIOMENA in February 2011, 16 (76%) out of 21 responding COMs reported providing international health involvement opportunities. 16 COMs reported that osteopathic medical students are allowed to serve clinical rotations, 10 COMs reported that they have established international clinical rotations, and 14 COMs reported having international clubs or interest groups focused on international health issues.

Many believe that osteopathic education will benefit from interactions between educational leaders that foster the development of consensus on global health competencies and that help establish learning objectives linked to corresponding educational approaches.4 Furthermore, with increased global mobility and the accompanying threats of emerging, re-emerging, and communicable diseases, the AOA and many COMs feel that future osteopathic physicians should be familiar with a wider range of illnesses and considerations for prevention and care. Therefore, despite associated costs and risks, some U.S. COMs are developing and refining educational experiences for medical students and residents in international sites (and culturally-distinctive enclaves in the United States). International

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2 For predoctoral education, the accrediting agency is the AOA Commission on Osteopathic College Accreditation (COCA); see their website at http://www.aoacoca.org. For postdoctoral education, multiple accrediting bodies are involved; see http://www.osteopathic.org/inside-aoa/accreditation/postdoctoral-training-approval/Pages/default.aspx.
health experience opportunities have been shown to preserve medical students’ idealism in developing a professional commitment and appreciation for cultural diversity and in dealing with global health concerns. Increasingly, international opportunities have become powerful recruiting tools for both undergraduate and graduate osteopathic medical school programs.

The AOA therefore encourages educational standardization of key component elements for such international and cultural enrichment programs. In order to foster safety, maximize educational outcomes and positively impact outcomes for osteopathic physicians-in-training, the AOA asked BIOMEA to identify key issues and resources.\(^5\)

The following ten (10) topics and two Appendices were summarized by BIOMEA; they make up the bulk of this White Paper, which also recommends guidelines on safe, effective, respectful and relevant international osteopathic health opportunities, in order to provide a blueprint for development of standards that consider curricular, cultural competency, and other logistical issues. This information should make osteopathic physicians and physicians-in-training more informed and better equipped to care for patients in this increasingly diverse and globalized world.

To meet this charge relative to international electives or planned rotations by an osteopathic physicians-in-training, the AOA recommends:

1. **Development of effective guidelines for international clinical clerkship curricula and its implementation**

   The AOA wishes to convey the benefits of this recommended outline for international/culturally-sensitive curricular components intended for COM students and OPTI residents who wish to have foreign clinical exposure. The following outline (as recommended by BIOMEA) is intended to assist individual COMs and OPTIs to uniformly address the issue of international educational interactions:

   1.1. The AOA requires professionalism abroad by its members and representatives. Osteopathic institutions, faculty, and physicians-in-training are therefore expected to demonstrate **respect, compassion** and **integrity**, as well as a commitment to ethical principles, and sensitivity to patients’ age, gender, religion, culture, disabilities, and impairments.

   1.2. The AOA encourages certain logistical steps in advance of undertaking international or culturally-related clerkships. A COM or OPTI, for example, may require a CV from the designated international site clinical preceptors to be available for both the curriculum committee and the physicians-in-training, in order to provide understanding of the

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\(^5\) BIOMEA is currently charged with reporting to the AOA Board of Trustees. Its current mission is stated as follows:

The mission of the Bureau on International Osteopathic Medical Education and Affairs (BIOMEA) is to provide organizational leadership that promotes the highest standards of osteopathic medical education and practice throughout the world and facilitates positive interactions between the AOA, AOA affiliates, and international health care organizations. The purpose is to ensure the continued contribution of the American model of osteopathic medicine in the United States (U.S.) and internationally.

BIOMEA seeks to facilitate those public and professional interactions, which increase the understanding and advancement of osteopathic medicine as a complete system of medical care. BIOMEA will promote the osteopathic philosophy that combines the needs of the patient with the current practice of medicine, surgery, and obstetrics, emphasizes the interrelationships between structure, function, and provides an appreciation of the body’s ability to heal itself.
preceptor’s background, affiliation, clinical teaching interests, cultural orientation or requirements, research interests, and professional affiliations.

1.3. The AOA encourages osteopathic physicians-in-training to be adequately oriented prior to departure. The “Know Triple A” (KAAA) mnemonic for example, would encourage osteopathic physicians-in-training engaging in clinical rotations abroad to Know and:

- **Appreciate** types of medical practice and delivery systems differing from U.S. health care delivery, including methods of controlling health care costs and allocating resources;
- **Advocate** for quality patient care, patient safety, and health promotion; and
- **Act** as an informal global ambassador for the AOA, his/her respective COM or OPTI, and, when appropriate, for osteopathic medical care.

Finally, osteopathic students should appreciate cultural diversity being observed in the host country.

1.4. The AOA strives for maximal interpersonal and communication skills. Osteopathic physicians-in-training are encouraged to demonstrate communication skills that result in effective information exchange. They are expected to create and sustain a therapeutic and ethically sound relationship with their patients (both in an international or in a culturally-sensitive community), use effective listening skills while working in the affiliated health care facility, and work effectively with others as a member or leader of a health care team. While being clinically-competent in a site or community, non-English language ability is not a requirement at all sites, this issue should be part of any discussion related to such a rotation.

1.5. The AOA encourages better understanding of the fundamentals of clinical competencies in COM-affiliated international and culturally-sensitive site(s). Physicians-in-training gaining added medical knowledge, expanded physical and history taking skills, interpersonal skills, language and communication skills, professionalism, cultural competency, and alternative health policy implications as well as practice-based learning are all examples of fundamentals meriting inclusion in such curricula.

1.6. The AOA encourages better understanding of the fundamentals of distinctively osteopathic clinical competencies, recognizing that osteopathic educators and researchers have identified a number of overseas clinics and institutions where the study or application of the osteopathic philosophical approach and/or integration of manual medicine or osteopathic techniques would provide new perspectives or opportunities for students to experience these within the context of different and sometimes unique patient populations. Ongoing interactions between members of the Osteopathic International Alliance (OIA) and formal exchanges of information between teachers and researchers representing their countries in the International Federation of Manual / Musculoskeletal Medicine (FIMM) have led to appreciation of such quality educational opportunities internationally.

1.7. The AOA encourages that all approved internationally- and culturally-based educational opportunities continue to also provide practice-based learning. Osteopathic physicians-in-training should be able to investigate and evaluate their patient care practices with the aid of their local preceptors, appraise and assimilate both scientific evidence and evidence-based osteopathic application to patient care whenever possible, understand indigenous
infectious conditions, appreciate cultural definitions of health and illness, be able to
demonstrate the ability to conduct a directed, full history and physical given language
limitations, and to improve their patient care practices while engaging in such clinical
electives.

1.8. With regard to assessment tools related to cultural competencies, a physician-in-training
portfolio generated during the clinical electives period is strongly encouraged. Standard
preceptor evaluations related to key cultural competencies could be an integral part of the
portfolio. A report from the host institution’s medical director (or equivalent) to delineate
physician-in-training behavior, cultural competencies, knowledge of medicine, degree of
clinical skills, and spirit of team work approach (individually or as a group) may also be
beneficial.

2. **Student, preceptor, and curricular evaluation of international electives**
The AOA recommends an official agreement pertaining to the expectations and responsibilities of
both the clinical preceptor and osteopathic physician-in-training. Rather than a shadowing
experience, the physician-in-training should be encouraged and allowed to provide hands-on clinical
activities, based on their experience level and abilities, in order to develop confidence in that
specific clinical setting. A template is illustrated in Appendix 1.

3. **Pre- and post-departure orientation concerns and needs**
Osteopathic training institutions and centers are encouraged to organize pre-departure orientation
curricula, developed at each COM or OPTI and directed by at least one faculty member. Students
interested in global health may also play a role in implementing the pre-departure orientation.

The following topics may be addressed:

3.1. Basic Health Precautions: Osteopathic physicians-in-training should understand basic
precautions including water and food safety, injury prevention (transportation), and vector-
borne illness prevention.

3.2. Insurance: Osteopathic physicians-in-training will most likely be required to acquire travel
health insurance either through their institution or commercially, and present proof of their
insurance to their institution.

3.3. Post-Exposure Prophylaxis (PEP): Osteopathic physicians-in-training should understand
appropriate PEP for HIV/AIDS, hepatitis, malaria, and tuberculosis and the steps to take
following exposure, as addressed in the immunizations/prophylaxis section.

3.4. Medical Care: Osteopathic physicians-in-training should most likely be advised to prepare a
small kit of personal medications before departing, including inhalers, antibiotics (as
appropriate), etc., and to identify in-country or regional health clinics and/or hospitals
where they can receive care if necessary.

3.5. Regional or Country-Specific Cultural Sensitivity Summary & References: It is highly
recommended that osteopathic physicians-in-training have access to a regional or country-
specific summary identifying key issues and differences related to health care delivery; local
understanding/status of osteopathic practitioners; culturally or medically vulnerable
groups; gender or caste biases; and any political/domestic issues of concern. This
summary could be linked to bibliographical and/or internet sites selected to expand upon key issues.

4. **Immunizations and prophylaxis**

The AOA recognizes the need for travel immunizations in a timely manner. An estimated 15% to 45% of short-term international travelers, including young adults, experience a health problem associated with their trip; albeit the majority being self-limiting viral infections. Virtually any place in the world can be reached within 36 hours, less than the incubation period for most infectious diseases. The ease with which people see the world has dramatically increased the number of international travelers. Respiratory infections, such as influenza and colds, develop in 10% and 25% of travelers. Women traveling to the tropics are at higher risk for urinary tract infections. As problematic, physicians in Western countries are now seeing infectious diseases never before encountered. Travelers are at risk both from infections transmitted from person to person and by insects (vector-borne diseases). Malaria, which is transmitted by mosquitoes, is the most widespread and infects between 300 and 500 million people world wide annually. Between 10,000 and 30,000 of these cases occur in travelers. Anyone traveling to high-risk countries should be advised or required to take precautions.

To this end, the AOA wishes all travelers to comply with CDC recommendation for immunizations and prophylaxis. With CDC requirements changing from time to time and location to location, consult [http://wwwnc.cdc.gov/travel/content/vaccinations.aspx](http://wwwnc.cdc.gov/travel/content/vaccinations.aspx) for the most up to date information.

5. **Travel documents and insurance**

Osteopathic training institutions and centers may facilitate sessions on various aspects of international travel for osteopathic physicians-in-training who need to obtain certain documents long before departing for an international clinical elective or other training. In many cases, osteopathic physicians-in-training will be naïve to the amount of time needed for some bureaucratic issues and should make sure of both timeline and processes for obtaining these documents as early as possible prior to a scheduled departure.

Documents that may require a significant amount of advance notice include:

5.1. Appropriately classified entry visa  
5.2. Passport  
5.3. Institutional Review Board (IRB) approval from COM/OPTI and/or international site if there are plans to participate in any research activity (regardless of who has initiated the protocol)  
5.4. International certificate of vaccinations

The main medicine-related documents that should be carried at all times are:

5.5. Copy of undergraduate diploma (if requested or required)  
5.6. Certificates of BLS (Basic Life Support/CPR) & ACLS (Advanced Cardiac Life Support Course)  
5.7. Additional certificates of education (RN degree, etc.)  
5.8. Letter from Dean or residency program director indicating their current medical school or post-graduate training status
Finally, certain optional travel documents may be recommended:

5.9. International Student Identity Card (ISIC)
5.10. International Driving Permit
5.11. Copies of prescriptions for any required medications

**Passports**

Passports are issued by the U.S. Department of State and are valid for 10 years. It is the most important document a traveler will carry abroad. A student/resident must complete the application, which can be done online; however, if this is the traveler’s first passport, the application should be made in person. The U.S. Department of State has a website that will help one to find the nearest location to apply.

When applying for a passport, the traveler must show proof of citizenship and proof of identity. Proof of citizenship can be given in the form of a birth certificate, but if the traveler does not have a birth certificate, a combination of the following documents can be used in its place:

- Letter of no birth record
- Baptismal certificate
- Hospital birth certificate
- Census record
- Early school record
- Family bible record
- Doctor record of postnatal care.

Permanent U.S. residents should contact their representative embassy regarding applying for a valid passport and specific requirements, which vary from country to country. Before departing, it is recommended to verify the validity requirements of the destination country. From the U.S. State Department website, “If possible … renew your passport approximately nine (9) months before it expires. Some countries require that your passport be valid at least six (6) months beyond the dates of your trip. Some airlines will not allow you to board if this requirement is not met.”

U.S. passport applicants will need two identical photographs, measuring 2” by 2”. Many pharmacies, stores, and travel agencies provide passport photo services. Please visit the U.S. Department of State website: http://travel.state.gov/passport/, for up to date passport fee structures.

**Visa**

Whether or not the traveler needs a visa (and which type of visa is needed) in order to pursue clinical elective training abroad depends on the country in which s/he plans on completing their rotation or clinical activity and how long s/he will be abroad. A visa can either be in the form of a separate document or a simple stamp on a passport and gives the traveler permission to enter a country and, in essence, live there for a period of time. The State Department website can tell the traveler if a visa is necessary for a specific destination. All U.S. permanent residents must contact the representative embassy of the country they plan to enter. Entry visa requirements vary from country to country depending on diplomatic relations. For more information, see: http://travel.state.gov/visa/.
International Certificate of Vaccinations
Travelers are advised to obtain an international certificate of vaccinations before their departure (see immunization/prophylaxis section). This document can be found at the local Department of Health, a travel agency, doctor's office or passport office. Travelers should make sure they have all necessary vaccinations. For up to date information on vaccinations and other health concerns, check the CDC website: http://wwwnc.cdc.gov/travel/content/vaccinations.aspx.

International Student Identity Card
Although not a requirement, The Council on International Education Exchange provides the International Student Identity Card (ISIC), which offers medical students discounts worldwide on things like travel fares, restaurants, shops, theaters, and hotels. It also carries medical benefits, worldwide assistance, and bankruptcy protection.

The ISIC offers basic medical benefits, covering medical expenses and emergency evacuation fees, up to a certain monetary amount. Students will also get worldwide assistance in the form of a toll-free 24/7 emergency number to call for help with lost passports and legal issues; operators speak 24 languages. The card also offers bankruptcy protection if a student's airline goes bankrupt. As a special bonus, students also receive an ISIC Global phone card with free talk time. For specific details on ISIC benefits and costs, visit http://www.isic.org/.

International Driving Permit
Many countries do not accept the U.S. driver's license, but most do accept the International Driving Permit (IDP). There are two organization authorized by the State Department to provide IDPs: the American Automobile Association (AAA – http://www.aaa.com), and the National Auto Club (http://www.thenac.com). To obtain an IDP, the applicant must be 18+ years old and present two passport-size photo, as well as a valid U.S. driver's license. The fee is less than $20.00. Visit http://travel.state.gov/travel/tips/safety/safety_1179.html, for more information.

The traveler will feel more prepared for the international elective experience once these documents are all in order.

6. Travel advisory alert and risk issues
Osteopathic training institutions and centers are encouraged to facilitate sessions discussing international travel advisory alerts and post-9/11 risks associated with certain regions of the world that are unfriendly toward the U.S. Measures should be taken to ensure that osteopathic physicians-in-training are adequately prepared for safe and responsible travel practices. When traveling abroad, the odds favor a safe and incident-free trip, however, travelers are sometimes the victims of crime and violence, or experience unexpected difficulties. No one is better able to explain this than the U.S. consular officers who work in the more than 250 U.S. embassies and consulates around the globe. Every day of the year, U.S. embassies and consulates receive calls from American citizens in distress. Happily, most problems can be solved over the telephone or by a visit to the Consular Section of the nearest U.S. embassy or consulate. There are other occasions, however, when consular officers are called upon to help U.S. citizens who are in foreign hospitals or prisons, or to assist the families of citizens who have passed away overseas. Therefore, the following travel tips will help travelers avoid serious difficulties during overseas travel.
Prior to Departure

What to Take

Safety begins when the traveler packs. To help avoid becoming a target, do not dress so as to appear to be an affluent tourist. Expensive-looking jewelry, for instance, can draw the wrong attention. Travelers are encouraged to travel light, primarily due to mobility issues.

Travelers are advised to carry the minimum number of valuables, and plan places to conceal them. Passports, driver's licenses, cash and credit cards are most secure when locked in a hotel safe. When the traveler has to carry them on person, s/he may wish to put them in various places rather than all in one wallet or pouch. Avoid handbags, fanny packs and outside pockets that are easy targets for thieves. Inside pockets and a sturdy shoulder bag with the strap worn across your chest are somewhat safer. One of the safest places to carry valuables is in a pouch or money belt worn under clothing. Travelers are advised to copy their passport, driver's license, and credit card(s) and leave the copies at home. In case any of these items are lost, copies can be used to help facilitate contact with the proper representative agencies that would re-issue the stolen item(s).

To avoid problems when passing through customs, keep medicines in their original, labeled containers. Bring copies of prescriptions and the generic names for the drugs. If a medication is unusual or contains narcotics, carry a letter from a doctor that attests to the traveler's need to take the drug. If there is any doubt about the legality of carrying a certain drug into a country, consult the embassy or consulate of that country before traveling. Bring travelers checks and one or two major credit cards instead of a huge amount of cash.

Travelers are advised to put their name, address and telephone numbers inside and outside of each piece of luggage. The use of covered luggage tags will help avoid casual observation of a traveler's identity or nationality; if possible, luggage should be locked.

Travelers should consider purchasing a telephone calling card, a convenient way of keeping in touch. However, verify that it can be used in the elective location(s). Access numbers to U.S. operators are published in many international newspapers. Find out the access number before leaving the U.S.

What to Leave Behind

Do not bring anything that would be unacceptable to lose. Leave at home:

- Valuable or expensive-looking jewelry
- Irreplaceable family objects
- All unnecessary credit cards
- Social Security card, library card, and similar items that may routinely be carried in a wallet.

Leave a copy of the travel itinerary with family or friends at home in case contact is necessary, in an emergency or otherwise. Make two photocopies of passport identification pages, airline tickets, driver's licenses and the credit cards that will be carried on the elective. Leave one photocopy of this data with family or friends at home; pack the other in a place separate from the originals. Also, leave a copy of the serial numbers of any traveler's checks with a friend or relative at home. Carry a copy in a separate place and cross them off the list as they are cashed.
What to Learn About Before Departing

Security

The Department of State's Country Specific Information is available for every country in the world. They describe entry requirements, currency regulations, unusual health conditions, the crime and security situation, political disturbances, areas of instability, and special information about driving and road conditions. They also provide addresses and emergency telephone numbers for U.S. embassies and consulates. In general, Country Specific Information does not give advice, but instead describes conditions so travelers can make informed decisions about their trips.

For some countries, however, the Department of State issues a Travel Warning in addition to Country Specific Information. The Travel Warning may recommend that Americans defer travel to that country because of a dangerous situation there.

Travel Alerts

Travel alerts are a means to disseminate information about relatively short-term conditions posing significant risk to the security of American travelers. They are issued when there is a perceived threat, even if it does not involve Americans as a particular target group. In the past, Travel Alerts have been issued to deal with coups, pre-election disturbances, and violence by terrorists and anniversary dates of specific terrorist events. Travelers can access Country Specific Information, Travel Warnings, and Travel Alerts 24-hours a day in several ways:

The Internet

The most convenient source of information about travel and consular services is the Consular Affairs home page. The website address is http://travel.state.gov.

Telephone

Overseas Citizens Services (OCS), at 1-888-407-4747, can answer general inquiries on safety and security overseas. This number is available from 8 a.m. to 8 p.m. Eastern Time, Monday through Friday (except U.S. federal holidays). Callers who are unable to use toll-free numbers, such as those calling from overseas, can obtain information and assistance from the OCS during these hours by calling +1-202-501-4444.

Local Laws and Customs

When leaving the U.S. travelers are subject to the laws of the country that is being visited. Therefore, before leaving, a traveler should learn as much as possible about the local laws and customs of the destination country. Good resources are libraries, travel agents, and embassies, consulates, or tourist bureaus of the countries to be visited. In addition, keep track of what is being reported in the media about recent developments in those countries.

7. Language issues

Osteopathic training institutions and centers are highly encouraged to either establish informal courses in languages such as Spanish and French (or any other international common languages), or establish an elective foreign language course with emphasis on medical terminology and basic aspects of patient history taking and patient communication. As verbal communication is the basis of any clinical interaction, it may be expected or even required that an osteopathic physician-in-training may have basic language proficiency when pursuing an international clinical elective in a language other than English. The following recommendations may help ensure abilities to elective
supervisors and build specific medical communication skills to facilitate their learning and effectiveness.

7.1. Language Basics: Osteopathic physicians-in-training should identify languages and language dialects spoken by patients in the area they will be working in advance of their elective. They should be aware that the local language used may be different from the official language of the host country or the language spoken by other health professionals. Osteopathic physicians-in-training should attempt to have a basic ability to communicate in the local language when feasible – especially at a site where a translator/interpreter is not available. This may include, for example, language training programs for weeks to months prior to departure or a similar program on-site.

7.2. Host Language Expectations: Osteopathic physicians-in-training should understand and comply with host expectations of language competency.

7.3. Interpreters: Osteopathic physicians-in-training should know whether they will be practicing with the assistance of an interpreter while on their elective. They should understand the role of interpreters in the medical interview and the constraints associated with use of family members and other health professionals as interpreters.

8. Ethical issues related to clinical and research electives
Osteopathic training institutions and centers are encouraged to conduct, sponsor or facilitate sessions to discuss possible ethical issues that travelers may encounter in the host country. Osteopathic physicians-in-training should be aware of the clinical and research ethical dimensions of studying and working abroad (especially in low-resource environments) and follow recognized standards of professional and ethical behavior.

8.1. Expectations of the Elective: It is recommended that osteopathic physicians-in-training should develop clear and appropriate goals and expectations – especially for electives in low-resource countries.

8.2. Understanding of Ethical Framework: Osteopathic physicians-in-training would benefit from being exposed to an array of potential ethical dilemmas prior to their departure that they may face while on international electives, and be provided with a framework to approach such problems.

8.3. Code of Conduct: The AOA strongly recommends that osteopathic training institutions and centers offer clear guidelines on professional behavior expectations for osteopathic physicians-in-training (especially on electives in low-resource settings), and should ensure that they are aware of these guidelines prior to departure. Ethical guidelines for international representatives are also covered in BIOMEA’s 2010 White Paper III. Furthermore, osteopathic physicians-in-training should be reminded of the imperative to “do no harm” while on electives.

8.4. International Research Activities: Osteopathic physicians-in-training and institutions must comply with ethical guidelines and all government regulations (here and abroad) pertaining to participation in any proposed research. To this end, they should therefore communicate closely with their own Institutional Review Board (IRB) prior to
committing to any form of international research activity. Furthermore, researchers need to appreciate the impact of relevant cultural issues in modifying the interpretation of certain core bioethical precepts governing research in the U.S. or by U.S. citizens abroad. Key international research guidelines, consensus documents dealing with international research ethics, and country-specific research ethical standard informational sources can be found in Appendix 2.

8.5. Appropriate Licensing: The AOA recommends that a clear chain of responsibility (COM/OPTI/student) be detailed to make sure that osteopathic physicians-in-training have the appropriate licenses/privileges and malpractice insurance required by the hosting institution. Furthermore, it is advised that both the COM and the osteopathic physicians-in-training ensure that their on-site supervisor has a clear understanding of the level of clinical skills/abilities/privileges in the United States.

8.6. Identified Contact Person: COMs and OPTIs with intermittent programs should consider ensuring that there is a faculty member or other specific contact identified with whom they may consult concerning ethical issues or other questions that arise while on site at an international placement. (Ideally this would be an individual specifically linked to the physician-in-training’s home institution.)

8.7. Supervision: COMs and OPTIs typically retain the responsibility for understanding the type and amount of supervision that will be available for their osteopathic physicians-in-training who are participating in an off-site elective. This supervision should be appropriate for the level of training the osteopathic physicians-in-training are undertaking.

9. Representation of the U.S. osteopathic profession
BIOMEA has previously held ambassador training sessions and developed some basic guidelines for physicians-in-training to remember when traveling internationally.

9.1. Dos and don’ts of international work
a. Do:
   • Conduct yourself in a professional manner at all times
   • Research the country and culture to be aware of differences that may be of importance
   • Be aware of personal cultural biases
   • Remember that because the U.S. osteopathic profession is not that well known outside our borders, the physician-in-training is a de facto representative of the entire profession
   • Make sure every team includes someone familiar with the country and culture
   • Slow down, be patient
   • Listen carefully – utilize both eyes and ears to this end
   • Words are secondary – 10% verbal – 90% non-verbal: body language can be incredibly powerful
   • “Break bread together;” meet, greet and eat; there are different ways of doing things

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6 For example, in many societies, health care decisions are the shared responsibility of family members and/or community leaders meaning that an individual cannot make a decision about medical care (actual or research) without full involvement of these others.
• Be flexible
• Recognize that public criticism can be a “big no-no” in certain cultures; likewise, public praise can also be objectionable in certain cultures
• Know/learn the culture of that country to try not to offend
• Know your strengths and use them

b. Don’t…
• Be a browbeater
• Be coercive
• Be the “Ugly American” who sometimes doesn’t even know when he or she is being overbearing
• Act manipulative
• Be arrogant
• Make assumptions
• Push too hard or too much

9.2. Policy Statements: If an osteopathic physician-in-training or a representative of a COM or OPTI seeking to set up an international rotation attends a meeting where an issue comes up for which they do not know what the AOA policy is, refrain from making any statements that could be attributed as AOA policy. When requested, the AOA and BIOMEA will provide osteopathic physicians-in-training with materials needed to provide a unified and consistent message regarding the U.S. osteopathic profession.

9.3. Clearinghouse: When possible, COMs or OPTIs will interview DOs or health officials from other countries to gather information about those countries and should report back to the AOA or BIOMEA representatives for use in the AOA’s international clearinghouse.

10. Recommended core “cultural competency” curricular components
BIOMEA encourages COMs and OPTIs to develop “cultural and linguistic” curricular components that reflect a set of congruent behaviors, knowledge, attitude, and policies that together strengthen osteopathic physicians’-in-training readiness to experience an international clinical elective in regions or communities where understanding of culture and basic linguistic background would be significant help to that individual. In doing so, the COMs/OPTIs may emphasize that:

10.1. Cultural competence in health care combines the tenets of patient/family-centered care with an understanding of the social and cultural influences that affect the quality of medical services and treatment.

10.2. With the ever-increasing diversity of the U.S. population and evidence of racial and ethnic disparities in health care, it is important that future health care professionals are educated specifically to address issues of culture in an effective manner.

10.3. Both faculty members and osteopathic physicians-in-training may demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illnesses and respond to various symptoms, disease, and treatments.
10.4. Osteopathic medical students and residents are encouraged to learn to recognize and appropriately address gender and cultural biases in health care delivery, while first considering the health needs of the patients.

10.5. Cultural Competence Curriculum

a. The aim of a cultural competence curriculum is to enhance the patient-health care provider interaction and to assure that osteopathic physicians-in-training have the knowledge, skills, and attitude that allow them to work effectively with patients and their families, as well as with other members of the health care community.

b. Health care professionals are encouraged to be educated to avoid stereotyping, but to also be aware of normative cultural values that can affect informed consent and can have serious consequences.

c. For a cultural competence curriculum to be effective, certain institutional requirements should be considered:
   i. Successful curricula have the support of the academic dean, faculty, director of medical education and physicians-in-training.
   ii. Institutional, community, and international resources (with special consideration to non-monetary resources) are typically combined into successful curricula.
   iii. Community/religious leaders may participate in the design of the curriculum and provide the necessary feedback, as may international medical and/or osteopathic collaborators.
   iv. Where possible, institutional commitment from faculty to design such a curriculum is best.
   v. In the most successful programs, the evaluation process is clearly defined.

10.6. Assessment of Osteopathic Physicians-in-Training in Cross-Cultural Education. Such an evaluation may include both qualitative and quantitative strategies required to appropriately assess the “impact” of cross-cultural curricula. The education approach may focus on:

a. ATTITUDES
   i. Examples
      1. Has the osteopathic physician-in-training learned the particular importance of curiosity, empathy, and respect in cross-cultural encounters?
      2. Does the osteopathic physician-in-training demonstrate these attitudes, as corroborated by evaluation?
   ii. Evaluation Strategy
      1. Standard surveying
      2. Structural interviewing
      3. Self-awareness assessment
      4. Presentation of clinical cases
      5. Objective structural clinical exam
      6. Videotaped/audio-taped clinical encounter

b. KNOWLEDGE
   i. Examples
      1. Has the osteopathic physician-in-training learned the key core cross-cultural issues, such as the styles of communication, mistrust,
prejudice, autonomy vs. family decision-making, customs relevant to health care and sexual/gender issues?

2. Does the osteopathic physician-in-training make an assessment of the key core cross-cultural issues, as corroborated by evaluation?

ii. Evaluation Strategy
   1. Tests (multiple choice, true-false, oral examination)
   2. Unknown clinical cases
   3. Presentation of clinical cases
   4. Objective structural clinical exam

   c. SKILLS
      i. Examples
         1. Has the osteopathic physician-in-training learned how to explore core cross-cultural issues and the explanatory model?
         2. Has the osteopathic physician-in-training learned how to effectively negotiate with a patient?
         3. Does the osteopathic physician-in-training explore the explanatory model and negotiate with a patient, as corroborated by evaluation?

      ii. Evaluation Strategy
         1. Presentation of clinical cases
         2. Objective structural exam
         3. Videotaped/audio-taped clinical encounter
APPENDIX 1 EXEMPLAR: Template for osteopathic physician-in-training evaluation of the international or culturally-relevant site program and clinical preceptor of the osteopathic medical physician-in-training.

1. Clinical experience
   i. Complete a thorough SOAP process or note
   ii. Complete examination of common chronic disorders (e.g., diabetic)
   iii. Practice history and physical exam skills
   iv. Develop communication skills with patients, nurses, and the attending
   v. Develop documentation skills
   vi. Develop professionalism in dress and behavior
   vii. Gain exposure to developing differential and treatment options
   viii. To fully understand and appreciate endemic diseases and their evidence-based clinical management
   ix. To be able to explain the concept of American model of osteopathic practice to the hospital staff including director of medical education

2. Hints for a positive experience for both the preceptor and student:
   i. Be aware of the osteopathic physician-in-training’s stage of professional knowledge and experience
   ii. International clinical preceptors should not assume the osteopathic physician-in-training has all of the facts, but rather expect them to be able to find the correct information with the best reliable and clinically-relevant answers

3. Osteopathic physician-in-training performance evaluation: the evaluation form should include the osteopathic physician-in-training’s name, international preceptor’s name and his/her specialty, and the elective date. The evaluation form could be categorized as following:
   i. Can’t judge/Never observed
   ii. Poor – unacceptable performance for this level of training
   iii. Needs improvement – for this level of training
   iv. Good – performance as expected with this level of training
   v. Very good – above average performance for this level of training
   vi. Outstanding

4. Consistently, osteopathic physician-in-training performance evaluation forms could include competencies such as:
   i. Medical and/or osteopathic medical knowledge
   ii. History taking
   iii. Physical exam
   iv. Problem solving/clinical judgment
   v. Progress notes
   vi. Informal patient presentation to the international clinical preceptor
   vii. Learning habits
   viii. Interpersonal relationships with patients
   ix. Reliability, initiative, and dependency
   x. Relationship with preceptor and staff
   xi. Language (and other communication) with patients
   xii. Cultural understanding and sensitivity
   xiii. General comments by international clinical preceptor
APPENDIX 2: Internet links to key guidelines and consensus documents dealing with international research ethics, plus a link to country-specific research ethical standard informational sources.

In planning international research or interfacing with global research partners, the following resources are either specifically designed to enhance an ethical approach to research or to assist in understanding cultural or regional issues (e.g., Islamic or Confucian ethics) that are currently being interpreted, discussed, or debated.

A training module resource entitled “International Study” created by the Collaborative Institutional Training Initiative (CITI):
https://www.citiprogram.org/irbpage.asp?language=english

Council for International Organizations of Medical Sciences (CIOMS) International Ethical Guidelines for Biomedical Research Involving Human Subjects:

Nuffield Council on Bioethics:
http://www.nuffieldbioethics.org/research-developing-countries

International Guidelines for Ethical Review of Epidemiological Studies:
Or order the latest version of the document from CIOMS:

World Health Organization’s Good Clinical Practice Guideline (WHO GCP):
http://apps.who.int/medicinedocs/pdf/whozip13e/whozip13e.pdf

Operational Guidelines for Ethics Committees that Review Biomedical Research:

Report and Recommendations of the U.S. National Bioethics Advisory Commission, April 2001:
http://bioethics.georgetown.edu/nbac/pubs.html

Global Health Competencies and Approaches in Medical Education: a literature review (existing curricular examples of what is currently in the literature):
http://www.biomedcentral.com/content/pdf/1472-6920-10-94.pdf

Follow this link for a table of country-specific internet addresses (ministries of health and other websites) with information to start researching a given country’s ethical review requirements:
https://www.citiprogram.org/members/learnersII/References.asp?intReferenceID=25856
AOA Bureau of International Osteopathic Medicine

WHITE PAPER
On
Guidelines for International Electives and Cultural Competencies
For Osteopathic Physicians-in-Training

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The American Osteopathic Association (AOA) recognizes the significant impact of culturally diverse perspectives, values, beliefs, traditions, and customs upon health care choices, health policy, and actual delivery of health care. It also appreciates that osteopathic physicians-in-training often gain valuable insights by participating in required or elective rotations at international sites. Furthermore, it recommends standardization of certain expectations for international clinical and/or research electives involving osteopathic physicians-in-training (students, interns and residents).

To facilitate safe, appropriate and meaningful expectations for such a curriculum and for international rotations, it is important that information gathering, collaboration and cooperative ventures by osteopathic institutions and representative bodies (including the American Association of Colleges of Osteopathic Medicine [AACOM] and individual colleges of osteopathic medicine [COM]) be conducted in a manner compatible with the AOA's educational and ethical standards. Furthermore, partnerships with collaborating institutions, when possible, should be based upon fostering mutual respect and mutual benefit, sharing information and resources, and minimizing the burden on host institutions -- especially while working in Least Developed Countries (LDC).

To these ends, the AOA has developed this White Paper. Its suggestions and guidelines will hopefully enable osteopathic medical students, as well as interns and residents, to experience quality clinical clerkships outside the United States while developing competencies in delivering care for patients of diverse cultural, ethnic and religious backgrounds. Equally important, the AOA desires that osteopathic physicians-in-training engaging in international clinical electives may informally yet appropriately serve as the ambassadors of the “profession” and propagate a better understanding of the American model of osteopathic education and care.

HISTORY & PURPOSE
In dealing with various international issues, the AOA has sought and continues to seek input and recommendations from its Bureau of International Osteopathic Medicine (BIOM) since formed as a Council in 1998. Furthermore, BIOM interacts directly with the AOA Board of Trustees to formulate and issue pertinent “White Papers” as informational pieces to describe the scope, direction, and activity of the AOA in the international arena. Topical “White Papers” also serve AOA leadership by providing pertinent background material for focused, informed discussions leading to future decisions or policy.

In 2009, BIOM recommended the development of and approval of a White Paper on Guidelines for Standardization of International Clinical Clerkship and Cultural Competency for COM Students.
Recognizing the applicability to interns and residents as well, this White Paper focuses on pertinent educational and logistical issues of preparing osteopathic physicians-in-training for the challenges of their clinical electives (at international sites). It also emphasizes the ethical interactions between components of U.S. COMs, international partners, and culturally-diverse communities in delivering such quality clinical clerkships consistent with the AACOM and AOA educational standards. Topics included:

1. Development of effective guidelines for clinical clerkship curricula in international sites
2. Student, preceptor, and curricular evaluation of electives in international sites
3. Pre- and post- international departure orientation concerns and needs
4. Immunizations and prophylaxis
5. Travel documents and insurance
6. Travel advisory alert and risk issues
7. Language issues in international sites
8. Ethical issues related to clinical and research electives
9. Representation of the U.S. osteopathic profession
10. Recommended core “cultural competency” curricular components towards understanding culture and customs of host countries sites

PREAMBLE
International health experiences can broaden a person’s perspective and provide a better understanding of the effect of health and illness on individuals and their culture. Such experiences have been shown to increase interest in global public health and primary care medicine for medical students and residents. For osteopathic physicians-in-training these experiences provide an opportunity not only to choose a career in international health but also to educate the global health community about the philosophy and practice of U.S. osteopathic medicine. Participation in an international rotation may also help osteopathic physicians-in-training to better understand opportunities and limitations related to the practice of osteopathic medicine generally and of manual treatment specifically in a given country or patient population.

Regardless of such interests, osteopathic physicians-in-training and the institutions in which they train must increasingly seek educational opportunities that are both meaningful and safe. Ideally, such “quality” educational health rotations will add to one or more of the following: knowledge of osteopathic medicine and philosophy, insights into indigenous or tropical medicine, broadening of general clinical skills, opportunity to witness or apply hands-on manual medicine practices, and acquire on-site cultural or language competency in order to prepare for the many challenges of 21st century health care delivery in diverse populations.

The benefits for each COM in the United States in developing international elective and cultural competency programs are becoming increasingly obvious, based particularly upon the growing interest of their students in engaging in international clinical rotations or humanitarian aid activities, interacting with culturally diverse populations, serving U.S. communities with large ethnic populations and witnessing the impact of certain health policies, especially in impoverished regions of the world (including parts of the United States). To this end, the AOA, as an internationally-linked and culturally-sensitive organization for osteopathic medical practice, seeks to broaden its involvement with the issues of international clinical electives for COM students. It also strongly
encourages each COM to consider and address the aforementioned issues to facilitate and streamline educational and logistical issues pertaining to students’ travel and hands-on clinical experience in a host country.

INTRODUCTION

The elements described in this document will be of value for participating osteopathic physicians and physicians-in-training at all stages of the continuum of osteopathic medical education, from predoctoral education through practice and continuing education. If students are participating in international experiences as part of their education, i.e. “for credit”, then these experiences would also need to satisfy any requirements of the respective AOA-recognized accrediting agency or approving committee.¹

Research indicates that international health experiences have positive educational outcomes, including increasing the likelihood of choosing a primary care career² and interest in serving underserved populations in the United States and abroad. The offering of such experiences can be attractive to applicants and can provide a wide range of clinical and cultural experiences for students and residents. Currently, 25 COMs report providing international health involvement opportunities for students, including short term trips and approval of international clinical rotations.

Many believe that osteopathic education will benefit from interactions between educational leaders that foster the development of consensus on global health competencies and that help establish learning objectives linked to corresponding educational approaches.³ Furthermore, with increased global mobility and the accompanying threats of emerging, re-emerging, and communicable diseases, the AOA and many COMs feel that future osteopathic physicians should be familiar with a wider range of illnesses and considerations for prevention and care. Therefore, despite associated costs and risks, some U.S. COMs are developing and refining educational experiences for medical students and residents in international sites. International health experience opportunities have been shown to preserve medical students’ idealism in developing a professional commitment and appreciation for cultural diversity and in dealing with global health concerns. Increasingly, international opportunities have become powerful recruiting tools for both undergraduate and graduate osteopathic medical school programs.

The AOA therefore encourages educational standardization of key component elements for such international and cultural enrichment programs. In order to foster safety, maximize educational outcomes and positively impact outcomes for osteopathic physicians-in-training, the AOA asked BIOM to identify key issues and resources.⁴

¹ For predoctoral education, the accrediting agency is the AOA Commission on Osteopathic College Accreditation (COCA); see their website at http://www.aoacoca.org. For postdoctoral education, multiple accrediting bodies are involved; see https://osteopathic.org/graduate-medical-educators/postdoctoral-training-standards/.


⁴ BIOM is currently charged with reporting to the AOA Board of Trustees. Its current mission is stated as follows:

The mission of the Bureau on International Osteopathic Medicine (BIOM) is to promote the highest standards of osteopathic medical education and practice throughout the world. The Bureau’s vision is acceptance of osteopathic medicine as a complete system of medical care
The following ten (10) topics and two Appendices were summarized by BIOM; they make up the bulk of this White Paper, which also recommends guidelines on safe, effective, respectful and relevant international osteopathic health opportunities, in order to provide a blueprint for development of standards that consider curricular, cultural competency, and other logistical issues. This information should make osteopathic physicians and physicians-in-training more informed and better equipped to care for patients in this increasingly diverse and globalized world.

To meet this charge relative to international electives or planned rotations by an osteopathic physicians-in-training, the AOA recommends:

1. Development of effective guidelines for international clinical clerkship curricula and its implementation

   The AOA wishes to convey the benefits of this recommended outline for international/culturally-sensitive curricular components intended for COM students and residencies with osteopathic recognition who wish to have foreign clinical exposure. The following outline (as recommended by BIOM) is intended to assist individual COMs and residencies with osteopathic recognition to uniformly address the issue of international educational interactions:

   1.1. The AOA requires professionalism abroad by its members and representatives. Osteopathic institutions, faculty, and physicians-in-training are therefore expected to demonstrate respect, compassion and integrity; as well as a commitment to ethical principles, and sensitivity to patients’ age, gender, religion, culture, disabilities, and impairments.

   1.2. The AOA encourages certain logistical steps in advance of undertaking international clerkships. A COM or residency with osteopathic recognition, for example, may require a CV from the designated international site clinical preceptors to be available for both the curriculum committee and the physicians-in-training, in order to provide understanding of the preceptor’s background, affiliation, clinical teaching interests, cultural orientation or requirements, research interests, and professional affiliations.

   1.3. The AOA encourages osteopathic physicians-in-training to be adequately oriented prior to departure. The “Know Triple A” (KAAA) mnemonic for example, would encourage osteopathic physicians-in-training engaging in clinical rotations abroad to Know and:

   throughout the world.

The Bureau will do this by providing organizational leadership that promotes the highest standards of osteopathic medical education and practice throughout the world and facilitates positive interactions between the AOA, AOA affiliates, and international healthcare organizations. The purpose is to ensure the continued contribution of the American model of osteopathic medicine in the United States (U.S.) and internationally.

The International Bureau seeks to facilitate those public and professional interactions, which increase the understanding and advancement of osteopathic medicine as a complete system of medical care. The BIOM will promote the osteopathic philosophy that combines the needs of the patient with the current practice of medicine, surgery, and obstetrics, emphasizes the interrelationships between structure, function, and provides an appreciation of the body’s ability to heal itself.
- **Appreciate** types of medical practice and delivery systems differing from U.S. health care delivery, including methods of controlling health care costs and allocating resources; **Appreciate** the cultural diversity being observed in the host country.
- **Advocate** for quality patient care, patient safety, and health promotion; and
- **Act** as an informal global ambassador for the AOA, his/her respective COM or residency with osteopathic recognition, and, when appropriate, for osteopathic medical care.

1.4. The AOA strives for maximal interpersonal and communication skills. Osteopathic physicians-in-training are encouraged to demonstrate communication skills that result in effective information exchange. They are expected to create and sustain a therapeutic and ethically sound relationship with their patients (in an international community), use effective listening skills while working in the affiliated health care facility, and work effectively with others as a member or leader of a health care team. While being clinically-competent in a site or community, non-English language ability is not a requirement at all sites, this issue should be part of any discussion related to such a rotation.

1.5. The AOA encourages better understanding of the fundamentals of clinical competencies in COM-affiliated international site(s). Physicians-in-training gaining added medical knowledge, expanded physical and history taking skills, interpersonal skills, language and communication skills, professionalism, cultural competency, and alternative health policy implications as well as practice-based learning are all examples of fundamentals meriting inclusion in such curricula.

1.6. The AOA encourages better understanding of the fundamentals of distinctively osteopathic clinical competencies, recognizing that osteopathic educators and researchers have identified a number of overseas clinics and institutions where the study or application of the osteopathic philosophical approach and/or integration of manual medicine or osteopathic techniques would provide new perspectives or opportunities for students to experience these within the context of different and sometimes unique patient populations. Ongoing interactions between members of the Osteopathic International Alliance (OIA) and formal exchanges of information between teachers and researchers representing their countries in the International Federation of Manual / Musculoskeletal Medicine (FIMM) have led to appreciation of such quality educational opportunities internationally.

1.7. The AOA encourages that all approved internationally based educational opportunities continue to also provide practice-based learning. Osteopathic physicians-in-training should be able to investigate and evaluate their patient care practices with the aid of their local preceptors, appraise and assimilate both scientific evidence and evidence-based osteopathic application to patient care whenever possible, understand indigenous infectious conditions, appreciate cultural definitions of health and illness, be able to demonstrate the ability to conduct a directed, full history and physical given language limitations, and to improve their patient care practices while engaging in such clinical electives.
1.8. With regard to assessment tools related to cultural competencies, a physician-in-training portfolio generated during the clinical electives period is strongly encouraged. Standard preceptor evaluations related to key cultural competencies could be an integral part of the portfolio. A report from the host institution’s medical director (or equivalent) to delineate physician-in-training behavior, cultural competencies, knowledge of medicine, degree of clinical skills, and spirit of team work approach (individually or as a group) may also be beneficial.

2. Student, preceptor, and curricular evaluation of international electives

The AOA recommends an official agreement pertaining to the expectations and responsibilities of both the clinical preceptor and osteopathic physician-in-training. Rather than a shadowing experience, the physician-in-training should be encouraged and allowed to provide hands-on clinical activities, based on their experience level and abilities, in order to develop confidence in that specific clinical setting. A template is illustrated in Appendix 1.

3. Pre- and post-departure orientation concerns and needs

Osteopathic training institutions and centers are encouraged to organize pre-departure orientation curricula, developed at each COM or residencies with osteopathic recognition and directed by at least one faculty member. Students interested in global health may also play a role in implementing the pre-departure orientation.

The following topics may be addressed:

3.1. Basic Health Precautions: Osteopathic physicians-in-training should understand basic precautions including water and food safety, injury prevention (transportation), and vector-borne illness prevention.

3.2. Insurance: Osteopathic physicians-in-training will most likely be required to acquire travel health insurance either through their institution or commercially, and present proof of their insurance to their institution.

3.3. Post-Exposure Prophylaxis (PEP): Osteopathic physicians-in-training should understand appropriate PEP for HIV/AIDS, hepatitis, malaria, and tuberculosis and the steps to take following exposure, as addressed in the immunizations/prophylaxis section.

3.4. Medical Care: Osteopathic physicians-in-training should most likely be advised to prepare a small kit of personal medications before departing, including inhalers, antibiotics (as appropriate), etc., and to identify in-country or regional health clinics and/or hospitals where they can receive care if necessary.

3.5. Regional or Country-Specific Cultural Sensitivity Summary & References: It is highly recommended that osteopathic physicians-in-training have access to a regional or country-specific summary identifying key issues and differences related to health care
delivery; local understanding/status of osteopathic practitioners; culturally or medically vulnerable groups; gender or caste biases; and any political/domestic issues of concern. This summary could be linked to bibliographical and/or internet sites selected to expand upon key issues.

4. Immunizations and prophylaxis

The AOA recognizes the need for travel immunizations in a timely manner. An estimated 15% to 45% of short-term international travelers, including young adults, experience a health problem associated with their trip; albeit the majority being self-limiting viral infections. Virtually any place in the world can be reached within 36 hours, less than the incubation period for most infectious diseases. The ease with which people see the world has dramatically increased the number of international travelers. Respiratory infections, such as influenza and colds, develop in 10% and 25% of travelers. Women traveling to the tropics are at higher risk for urinary tract infections. As problematic, physicians in Western countries are now seeing infectious diseases never before encountered. Travelers are at risk both from infections transmitted from person to person and by insects (vector-borne diseases). Malaria, which is transmitted by mosquitoes, is the most widespread and infects between 300 and 500 million people world wide annually. Between 10,000 and 30,000 of these cases occur in travelers. Anyone traveling to high-risk countries should be advised or required to take precautions.

To this end, the AOA wishes all travelers to comply with CDC recommendation for immunizations and prophylaxis. With CDC requirements changing from time to time and location to location, consult http://wwwnc.cdc.gov/travel/content/vaccinations.aspx for the most up to date information.

5. Travel documents and insurance

Osteopathic training institutions and centers may facilitate sessions on various aspects of international travel for osteopathic physicians-in-training who need to obtain certain documents long before departing for an international clinical elective or other training. In many cases, osteopathic physicians-in-training will be naïve to the amount of time needed for some bureaucratic issues and should make sure of both timeline and processes for obtaining these documents as early as possible prior to a scheduled departure.

Documents that may require a significant amount of advance notice include:

5.1. Appropriately classified entry visa
5.2. Passport
5.3. Institutional Review Board (IRB) approval from COM/residency with osteopathic recognition and/or international site if there are plans to participate in any research activity (regardless of who has initiated the protocol)
5.4. International certificate of vaccinations

The main medicine-related documents that should be carried at all times are:
5.5. Copy of undergraduate diploma (if requested or required)
5.6. Certificates of BLS (Basic Life Support/CPR) & ACLS (Advanced Cardiac Life Support Course)
5.7. Additional certificates of education (RN degree, etc.)
5.8. Letter from Dean or residency program director indicating their current medical school or post-graduate training status

Finally, certain optional travel documents may be recommended:

5.9. International Student Identity Card (ISIC)
5.10. International Driving Permit
5.11. Copies of prescriptions for any required medications

**Passports**

Passports are issued by the U.S. Department of State and are valid for 10 years. It is the most important document a traveler will carry abroad. A student/resident must complete the application, which can be done online; however, if this is the traveler's first passport, the application should be made in person. The U.S. Department of State has a website that will help one to find the nearest location to apply.

When applying for a passport, the traveler must show proof of citizenship and proof of identity. Proof of citizenship can be given in the form of a birth certificate, but if the traveler does not have a birth certificate, a combination of the following documents can be used in its place:

- Letter of no birth record
- Baptismal certificate
- Hospital birth certificate
- Census record
- Early school record
- Family bible record
- Doctor record of postnatal care.

Permanent U.S. residents should contact their representative embassy regarding applying for a valid passport and specific requirements, which vary from country to country. Before departing, it is recommended to verify the validity requirements of the destination country. From the U.S. State Department website, “If possible … renew your passport approximately nine (9) months before it expires. Some countries require that your passport be valid at least six (6) months beyond the dates of your trip. Some airlines will not allow you to board if this requirement is not met.”

U.S. passport applicants will need two identical photographs, measuring 2” by 2”. Many pharmacies, stores, and travel agencies provide passport photo services. Please visit the U.S. Department of State website: [http://travel.state.gov/passport/](http://travel.state.gov/passport/), for up to date passport fee structures.

**Visa**

Whether or not the traveler needs a visa (and which type of visa is needed) in order to pursue clinical elective training abroad depends on the country in which s/he plans on completing their
rotation or clinical activity and how long s/he will be abroad. A visa can either be in the form of a separate document or a simple stamp on a passport and gives the traveler permission to enter a country and, in essence, live there for a period of time. The State Department website can tell the traveler if a visa is necessary for a specific destination. All U.S. permanent residents must contact the representative embassy of the country they plan to enter. Entry visa requirements vary from country to country depending on diplomatic relations. For more information, see: http://travel.state.gov/visa/.

6. Travel advisory alert and risk issues

Osteopathic training institutions and centers are encouraged to facilitate sessions discussing international travel advisory alerts and post-9/11 risks associated with certain regions of the world that are unfriendly toward the U.S. Measures should be taken to ensure that osteopathic physicians-in-training are adequately prepared for safe and responsible travel practices. When traveling abroad, the odds favor a safe and incident-free trip, however, travelers are sometimes the victims of crime and violence, or experience unexpected difficulties. No one is better able to explain this than the U.S. consular officers who work in the more than 250 U.S. embassies and consulates around the globe. Every day of the year, U.S. embassies and consulates receive calls from American citizens in distress. Happily, most problems can be solved over the telephone or by a visit to the Consular Section of the nearest U.S. embassy or consulate. There are other occasions, however, when consular officers are called upon to help U.S. citizens who are in foreign hospitals or prisons, or to assist the families of citizens who have passed away overseas. Therefore, the following travel tips will help travelers avoid serious difficulties during overseas travel.
Prior to Departure

What to Take

Safety begins when the traveler packs. To help avoid becoming a target, do not dress so as to appear to be an affluent tourist. Expensive-looking jewelry, for instance, can draw the wrong attention. Travelers are encouraged to travel light, primarily due to mobility issues.

Travelers are advised to carry the minimum number of valuables, and plan places to conceal them. Passports, driver’s licenses, cash and credit cards are most secure when locked in a hotel safe. When the traveler has to carry them on person, s/he may wish to put them in various places rather than all in one wallet or pouch. Avoid handbags, fanny packs and outside pockets that are easy targets for thieves. Inside pockets and a sturdy shoulder bag with the strap worn across your chest are somewhat safer. One of the safest places to carry valuables is in a pouch or money belt worn under clothing. Travelers are advised to copy their passport, driver’s license, and credit card(s) and leave the copies at home. In case any of these items are lost, copies can be used to help facilitate contact with the proper representative agencies that would re-issue the stolen item(s).

To avoid problems when passing through customs, keep medicines in their original, labeled containers. Bring copies of prescriptions and the generic names for the drugs. If a medication is unusual or contains narcotics, carry a letter from a doctor that attests to the traveler’s need to take the drug. If there is any doubt about the legality of carrying a certain drug into a country, consult the embassy or consulate of that country before traveling. Bring travelers checks and one or two major credit cards instead of a huge amount of cash.

Travelers are advised to put their name, address and telephone numbers inside and outside of each piece of luggage. The use of covered luggage tags will help avoid casual observation of a traveler’s identity or nationality; if possible, luggage should be locked.

Travelers should consider activating international roaming feature with their cellphone provider in order to be able to keep in touch.

What to Leave Behind

Do not bring anything that would be unacceptable to lose. Leave at home:

- Valuable or expensive-looking jewelry
- Irreplaceable family objects
- All unnecessary credit cards
- Social Security card, library card, and similar items that may routinely be carried in a wallet.

Leave a copy of the travel itinerary with family or friends at home in case contact is necessary, in an emergency or otherwise. Make two photocopies of passport identification pages, airline tickets, driver’s licenses and the credit cards that will be carried on the elective. Leave one photocopy of this data with family or friends at home; pack the other in a place separate from the originals.
What to Learn About Before Departing

Security
The Department of State's Country Specific Information is available for every country in the world. They describe entry requirements, currency regulations, unusual health conditions, the crime and security situation, political disturbances, areas of instability, and special information about driving and road conditions. They also provide addresses and emergency telephone numbers for U.S. embassies and consulates. In general, Country Specific Information does not give advice, but instead describes conditions so travelers can make informed decisions about their trips.

For some countries, however, the Department of State issues a Travel Warning in addition to Country Specific Information. The Travel Warning may recommend that Americans defer travel to that country because of a dangerous situation there.

Travelers are recommended to enroll in the State Department’s Smart Traveler Enrollment Program (STEP). This program alerts provides travel alerts and also allows the relevant US consular office to keep track of Americans in-country in the event of a natural disaster, political upheaval, etc.

Travel Alerts
Travel alerts are a means to disseminate information about relatively short-term conditions posing significant risk to the security of American travelers. They are issued when there is a perceived threat, even if it does not involve Americans as a particular target group. In the past, Travel Alerts have been issued to deal with coups, pre-election disturbances, and violence by terrorists and anniversary dates of specific terrorist events. Travelers can access Country Specific Information, Travel Warnings, and Travel Alerts 24-hours a day in several ways:

- The most convenient source of information about travel and consular services is the Consular Affairs home page. The website address is http://travel.state.gov.
- Overseas Citizens Services (OCS), at 1-888-407-4747, can answer general inquiries on safety and security overseas. This number is available from 8 a.m. to 8 p.m. Eastern Time, Monday through Friday (except U.S. federal holidays). Callers who are unable to use toll-free numbers, such as those calling from overseas, can obtain information and assistance from the OCS during these hours by calling +1-202-501-4444.
- When leaving the U.S. travelers are subject to the laws of the country that is being visited. Therefore, before leaving, a traveler should learn as much as possible about the local laws and customs of the destination country. Good resources are libraries, travel agents, and embassies, consulates, or tourist bureaus of the countries to be visited. In addition, keep track of what is being reported in the media about recent developments in those countries.

7. Language issues

Osteopathic training institutions and centers are highly encouraged to either establish informal courses in languages such as Spanish and French (or any other international common languages), or establish an elective foreign language course with emphasis on medical terminology and basic aspects of patient history taking and patient communication. As verbal communication is the
basis of any clinical interaction, it may be expected or even required that an osteopathic physician-in-training may have basic language proficiency when pursuing an international clinical elective in a language other than English. The following recommendations may help ensure abilities to elective supervisors and build specific medical communication skills to facilitate their learning and effectiveness.

7.1. Language Basics: Osteopathic physicians-in-training should identify languages and language dialects spoken by patients in the area they will be working in advance of their elective. They should be aware that the local language used may be different from the official language of the host country or the language spoken by other health professionals. Osteopathic physicians-in-training should attempt to have a basic ability to communicate in the local language when feasible – especially at a site where a translator/interpreter is not available. This may include, for example, language training programs for weeks to months prior to departure or a similar program on-site.

7.2. Host Language Expectations: Osteopathic physicians-in-training should understand and comply with host expectations of language competency.

7.3. Interpreters: Osteopathic physicians-in-training should know whether they will be practicing with the assistance of an interpreter while on their elective. They should understand the role of interpreters in the medical interview and the constraints associated with use of family members and other health professionals as interpreters.

8. Ethical issues related to clinical and research electives

Osteopathic training institutions and centers are encouraged to conduct, sponsor or facilitate sessions to discuss possible ethical issues that travelers may encounter in the host country. Osteopathic physicians-in-training should be aware of the clinical and research ethical dimensions of studying and working abroad (especially in low-resource environments) and follow recognized standards of professional and ethical behavior.

8.1. Expectations of the Elective: It is recommended that osteopathic physicians-in-training should develop clear and appropriate goals and expectations – especially for electives in low-resource countries.

8.2. Understanding of Ethical Framework: Osteopathic physicians-in-training would benefit from being exposed to an array of potential ethical dilemmas prior to their departure that they may face while on international electives, and be provided with a framework to approach such problems.

8.3. Code of Conduct: The AOA strongly recommends that osteopathic training institutions and centers offer clear guidelines on professional behavior expectations for osteopathic physicians-in-training (especially on electives in low-resource settings), and should ensure that they are aware of these guidelines prior to departure. Furthermore, osteopathic physicians-in-training should be reminded of the imperative to “do no harm” while on electives.
8.4. International Research Activities: Osteopathic physicians-in-training and institutions must comply with ethical guidelines and all government regulations (here and abroad) pertaining to participation in any proposed research. To this end, they should therefore communicate closely with their own Institutional Review Board (IRB) prior to committing to any form of international research activity. Furthermore, researchers need to appreciate the impact of relevant cultural issues in modifying the interpretation of certain core bioethical precepts governing research in the U.S. or by U.S. citizens abroad. Key international research guidelines, consensus documents dealing with international research ethics, and country-specific research ethical standard informational sources can be found in Appendix 2.

8.5. Appropriate Licensing: The AOA recommends that a clear chain of responsibility (COM/ residencies with osteopathic recognition/student) be detailed to make sure that osteopathic physicians-in-training have the appropriate licenses/privileges and malpractice insurance required by the hosting institution. Furthermore, it is advised that the proper authorities in the country where international activities are conducted have been informed and approve of the purpose of international activities of osteopathic physicians, residents and students in their nation.

8.6. Identified Contact Person: COMs and residencies with osteopathic recognition with intermittent programs should consider ensuring that there is a faculty member or other specific contact identified with whom they may consult concerning ethical issues or other questions that arise while on site at an international placement. (Ideally this would be an individual specifically linked to the physician-in-training’s home institution.)

8.7. Supervision: COMs and residencies with osteopathic recognition typically retain the responsibility for understanding the type and amount of supervision that will be available for their osteopathic physicians-in-training who are participating in an off-site elective. This supervision should be appropriate for the level of training the osteopathic physicians-in-training are undertaking.

8.8. Under the ethical tenets of the profession, osteopathic physicians and learners routinely care for others despite personal risk. Appropriate safeguards such as proper personal protective equipment (PPE) are important for protecting the health of their patients, as well as their own health and that of their families. Health care workers are professionally bound to identify inadequate resources that impact their ability to safely treat patients or keep themselves safe. Individuals must not suffer retribution or retaliation for calling attention to unsafe systemic conditions for patients or caregivers.

9. Representation of the U.S. osteopathic profession

BIOM has previously held ambassador training sessions and developed some basic guidelines for physicians-in-training to remember when traveling internationally.

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5 For example, in many societies, health care decisions are the shared responsibility of family members and/or community leaders meaning that an individual cannot make a decision about medical care (actual or research) without full involvement of these others.
9.1. Dos and don’ts of international work
   a. Do:
      • Conduct yourself in a professional manner at all times
      • Remember that because the U.S. osteopathic profession is not that well known outside our borders, the physician-in-training is a de facto representative of the entire profession
      • Research the country and culture to be aware of differences that may be of importance
      • Know/learn the culture of that country to try not to offend
      • Be aware of personal cultural biases
      • Make sure every team includes someone familiar with the country and culture
      • Slow down, be patient
      • Listen carefully – utilize both eyes and ears to this end
      • Words are secondary – 10% verbal – 90% non-verbal: body language can be incredibly powerful
      • “Break bread together;” meet, greet and eat; there are different ways of doing things
      • Be flexible
      • Recognize that public criticism can be a “big no-no” in certain cultures; likewise, public praise can also be objectionable in certain cultures
      • Know your strengths and use them
   b. Don’t…
      • Make assumptions
      • Be a browbeater
      • Be coercive
      • Be the “Ugly American” who sometimes doesn’t even know when he or she is being overbearing (e.g. speak loudly to handle a language difficulty)
      • Act manipulative
      • Be arrogant
      • Push too hard or too much

9.2. Policy Statements: If an osteopathic physician-in-training or a representative of a COM or residencies with osteopathic recognition seeking to set up an international rotation attends a meeting where an issue comes up for which they do not know what the AOA policy is, refrain from making any statements that could be attributed as AOA policy. When requested, the AOA and BIOM will provide osteopathic physicians-in-training with materials needed to provide a unified and consistent message regarding the U.S. osteopathic profession.

9.3. Clearinghouse: When possible, COMs or residencies with osteopathic recognition will interview DOs or health officials from other countries to gather information about
those countries and should report back to the AOA or BIOM representatives for use in
the AOA’s international clearinghouse.

10. Recommended core “cultural competency” curricular components

BIOM encourages COMs and residencies with osteopathic recognition to develop “cultural and
linguistic” curricular components that reflect a set of congruent behaviors, knowledge, attitude,
and policies that together strengthen osteopathic physicians’-in-training readiness to experience
an international clinical elective in regions or communities where understanding of culture and
basic linguistic background would be significant help to that individual. In doing so, the COMs/
residencies with osteopathic recognition may emphasize that:

10.1. Cultural competence in health care combines the tenets of patient/family-centered care
with an understanding of the social and cultural influences that affect the quality of
medical services and treatment.

10.2. With the ever-increasing diversity of the U.S. population and evidence of racial and
ethnic disparities in health care, it is important that future health care professionals are
educated specifically to address issues of culture in an effective manner.

10.3. Both faculty members and osteopathic physicians-in-training may demonstrate an
understanding of the manner in which people of diverse cultures and belief systems
perceive health and illnesses and respond to various symptoms, disease, and
treatments.

10.4. Osteopathic medical students and residents are encouraged to learn to recognize and
appropriately address gender and cultural biases in health care delivery, while first
considering the health needs of the patients.

10.5. Cultural Competence Curriculum
   a. The aim of a cultural competence curriculum is to enhance the patient and health
care provider interaction, and to assure that osteopathic physicians-in-training
have the knowledge, skills, and attitude that allow them to work effectively with
patients and their families, as well as with other members of the health care
community.
   b. Health care professionals are encouraged to be educated to avoid stereotyping,
but to also be aware of normative cultural values that can affect informed
consent and can have serious consequences.
   c. For a cultural competence curriculum to be effective, certain institutional
requirements should be considered:
      i. Successful curricula have the support of the academic dean, faculty,
director of medical education and physicians-in-training.
      ii. Institutional, community, and international resources (with special
consideration to non-monetary resources) are typically combined into
successful curricula.
iii. Community/religious leaders may participate in the design of the curriculum and provide the necessary feedback, as may international medical and/or osteopathic collaborators.

iv. Where possible, institutional commitment from faculty to design such a curriculum is best.

v. In the most successful programs, the evaluation process is clearly defined.

10.6. Assessment of Osteopathic Physicians-in-Training in Cross-Cultural Education. Such an evaluation may include both qualitative and quantitative strategies required to appropriately assess the “impact” of cross-cultural curricula. The education approach may focus on:

a. ATTITUDES

i. Examples
   1. Has the osteopathic physician-in-training learned the particular importance of curiosity, empathy, and respect in cross-cultural encounters?
   2. Does the osteopathic physician-in-training demonstrate these attitudes, as corroborated by evaluation?

ii. Evaluation Strategy
   1. Standard surveying
   2. Structural interviewing
   3. Self-awareness assessment
   4. Presentation of clinical cases
   5. Objective structural clinical exam
   6. Videotaped/audio-taped clinical encounter

b. KNOWLEDGE

i. Examples
   1. Has the osteopathic physician-in-training learned the key core cross-cultural issues, such as the styles of communication, mistrust, prejudice, autonomy vs. family decision-making, customs relevant to health care, and sexual/gender issues?
   2. Does the osteopathic physician-in-training make an assessment of the key core cross-cultural issues, as corroborated by evaluation?

ii. Evaluation Strategy
   1. Tests (multiple choice, true-false, oral examination)
   2. Unknown clinical cases
   3. Presentation of clinical cases
   4. Objective structural clinical exam

c. SKILLS

i. Examples
   1. Has the osteopathic physician-in-training learned how to explore core cross-cultural issues?
   2. Has the osteopathic physician-in-training learned how to effectively negotiate with a patient?
   3.

ii. Evaluation Strategy
   1. Presentation of clinical cases
1. Objective structural exam
2. Videotaped/audio-taped clinical encounter
APPENDIX 1 EXEMPLAR: Template for osteopathic physician-in-training evaluation of the international site program and clinical preceptor of the osteopathic medical physician-in-training.

1. Clinical experience
   i. To be able to explain the concept of American model of osteopathic practice to the hospital staff including director of medical education
   ii. Complete a thorough SOAP process or note
   iii. Complete examination of common chronic disorders (e.g., diabetic)
   iv. Practice history and physical exam skills
   v. Develop communication skills with patients, nurses, and the attending
   vi. Develop documentation skills
   vii. Develop professionalism in dress and behavior
   viii. Gain exposure to developing differential and treatment options
   ix. To fully understand and appreciate endemic diseases and their evidence-based clinical management

2. Hints for a positive experience for both the preceptor and student:
   i. Be aware of the osteopathic physician-in-training’s stage of professional knowledge and experience
   ii. International clinical preceptors should not assume the osteopathic physician-in-training has all of the facts, but rather expect them to be able to find the correct information with the best reliable and clinically-relevant answers

3. Osteopathic physician-in-training performance evaluation: the evaluation form should include the osteopathic physician-in-training’s name, international preceptor’s name and his/her specialty, and the elective date. The evaluation form could be categorized as following:
   i. Can’t judge/Never observed
   ii. Poor – unacceptable performance for this level of training
   iii. Needs improvement – for this level of training
   iv. Good – performance as expected with this level of training
   v. Very good – above average performance for this level of training
   vi. Outstanding

4. Consistently, osteopathic physician-in-training performance evaluation forms could include competencies such as:
   i. Medical and/or osteopathic medical knowledge
   ii. History taking
   iii. Physical exam
   iv. Problem solving/clinical judgment
   v. Progress notes
   vi. Informal patient presentation to the international clinical preceptor
   vii. Learning habits
   viii. Interpersonal relationships with patients
   ix. Reliability, initiative, and dependency
   x. Relationship with preceptor and staff
   xi. Language (and other communication) with patients
   xii. Cultural understanding and sensitivity
xiii. General comments by international clinical preceptor

APPENDIX 2: Internet links to key guidelines and consensus documents dealing with international research ethics, plus a link to country-specific research ethical standard informational sources.

In planning international research or interfacing with global research partners, the following resources are either specifically designed to enhance an ethical approach to research or to assist in understanding cultural or regional issues (e.g., Islamic or Confucian ethics) that are currently being interpreted, discussed, or debated.

Council for International Organizations of Medical Sciences (CIOMS) International Ethical Guidelines for Biomedical Research Involving Human Subjects:
https://cioms.ch/shop/product/international-ethical-guidelines-for-biomedical-research-involving-human-subjects-2/

Nuffield Council on Bioethics:
http://www.nuffieldbioethics.org/research-developing-countries

International Guidelines for Ethical Review of Epidemiological Studies:
Or order the latest version of the document from CIOMS:

World Health Organization's Good Clinical Practice Guideline (WHO GCP):
http://apps.who.int/medicinedocs/pdf/whozip13e/whozip13e.pdf

Operational Guidelines for Ethics Committees that Review Biomedical Research:

Report and Recommendations of the U.S. National Bioethics Advisory Commission, April 2001:
http://bioethics.georgetown.edu/nbac/pubs.html

Global Health Competencies and Approaches in Medical Education: a literature review (existing curricular examples of what is currently in the literature):
http://www.biomedcentral.com/content/pdf/1472-6920-10-94.pdf
WHEREAS, the American Osteopathic Association’s Commission on Osteopathic College Accreditation (COCA) is responsible for the institutional and programmatic accreditation of colleges of osteopathic medicine and setting standards to be used in accreditation decisions; and

WHEREAS, the new COCA standards are labor-intensive, requiring considerable hands-on consultation with established and developing COMs; and

WHEREAS, many COMs have institutional accreditation through the regional accreditor for their parent university and only utilize COCA for programmatic accreditation; and

WHEREAS, COMs where the COCA is the institutional accreditor require additional monitoring and reporting to the U.S. Department of Education; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) approve assessment of a separate accreditation fees for COMs where the COCA is the institutional accreditor by $15,000 per year.

Explanatory Statement:
At present four COMs utilize the COCA for both institutional and programmatic accreditation. This resolution approves a separate charge for institutional accreditation services to offset the costs incurred to provide institutional accreditation.

FISCAL IMPACT: $60,000
FY 2021 Revenue Increase: $60,000

ACTION TAKEN _______________________

DATE _________________________
RES. NO. B-4 – A/2020- Page 1

SUBJECT: REVISIONS TO THE HANDBOOK OF THE BUREAU OF OSTEOPATHIC SPECIALISTS

SUBMITTED BY: Bureau of Osteopathic Specialists

REFERRED TO: AOA Board of Trustees

RESOLVED, that the following revisions to the Handbook Bureau of Osteopathic Specialist -
be APPROVED; and, be it further

RESOLVED, that these policies be effective immediately following approval of the AOA
Board of Trustees.

Strikethrough (abcd) used on old material | New material in all CAPS and bolded

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Article IV. Specialty Certifying Board Operating Procedures

As subcommittees of the Bureau of Osteopathic Specialists (BOS), all AOA specialty certifying
boards are governed by this handbook as well as BOS policy & procedures.

Section 1. Duties

The duties of an American Osteopathic Association (AOA) specialty certifying board
(hereinafter referred to as “board”) are to:

A. Serve as an advisory body for all applicants for certification in a specialty(ies) and
subspecialty and/or certification of added qualifications which may be assigned to its
jurisdiction.

B. Recommend to the BOS and AOA Board of Trustees (AOA-BOT) the standards of
education and formal training AND/OR EXPERIENCE required for certification in a
specialty(ies) and any other subspecialty and/or certification of added qualifications which
may be assigned to its jurisdiction.

C. Make recommendations to the BOS concerning each applicant’s eligibility for initial
certification as well as compliance with Osteopathic Continuous Certification (OCC).

D. Issue certificates in all specialties, and subspecialties AND/OR CERTIFICATION OF
ADDED QUALIFICATIONS assigned to the board.

E. In conjunction with the Certification Compliance Review Committee (CCRC), recommend
revocation of a certificate CERTIFICATION.

F. Recommend APPOINT a QUALIFIED member of the board to SERVE as a BOS
representative on the BOS as well as identifieMENT OF AND APPOINT an alternate
REPRESENTATIVE.

G. In collaboration with the SENIOR Vice President of Certifying Board Services (SVP-CBS),
establish processes whereby diplomates may maintain certification (OCC) in accordance
with AOA policy.

H. In collaboration with the SVP-CBS, develop and maintain best practices for physician
credentialing, AND certification, and OCC.
I. Ensure the delivery of relevant and osteopathically distinct examination processes and methodologies.

J. Serve as ambassadors for osteopathic MARKETING AOA board certification with program directors, RESIDENTS, DIPLOMATES and other STAKEHOLDERS officials identifying, marketing, and preparing candidates for AOA certification.

K. Develop and maintain items to produce psychometrically defensible and osteopathically distinct examinations in the practice areas assigned to the board.

L. Collaborate with the SVP-CBS, and other AOA team members to ensure the examination process of the board is fiscally viable and appeals to the target demographic.

M. Maintain strict confidentiality of all applicant information, test content and scoring methods.

N. Ensure all physicians participating in examination development and delivery are engaged MUST BE in the practice of medicine or ACTIVELY ENGAGED IN CLINICAL PRACTICE, TEACHING PHYSICIANS, OR SERVING IN AN ADMINISTRATIVE ROLE serving in an administrative role.

Section 2. Committee CERTIFYING BOARD Membership

A. Membership

1. Membership on a board should have a minimum of five (5) members and NO MORE THAN will be limited to a maximum of eight (8) members; with the chair only voting in cases where there is a tie vote. AN EXCEPTION TO THE MAXIMUM NUMBER OF BOARD MEMBERS MAY BE MADE FOR BOARDS THAT HAVE MORE THAN EIGHT SUBSPECIALTIES OR THOSE BOARDS WITH EXPANDED/COMPLEX OPERATIONAL NEEDS REQUIRING ADDITIONAL PHYSICIAN LEADERSHIP. BOARDS REQUESTING MORE THAN EIGHT BOARD MEMBERS MUST SUBMIT A PROPOSAL TO THE BOS EXECUTIVE COMMITTEE, WHICH EXPLAINS THE RATIONALE AS TO WHY THEY REQUIRE ADDITIONAL BOARD MEMBERS.

2. The board will seek AOA-board certified nominees and should MUST submit a minimum of 2 nominations FOR APPROVAL ONE (1) NOMINATION, INCLUDING CV, to the BOS FOR EACH OPEN POSITION ON THE BOARD IN THE CASE OF NEW APPOINTMENTS OR RE-ELECTIONS. IF APPROVED, THE BOS will make A recommendations to the AOA-BOT, who will make the final decision regarding appointments to the board. IF NOT APPROVED, A NEW NOMINATION, INCLUDING CV, MUST BE SUBMITTED.

3. Members of boards must be AOA board-certified and participating in the OCC process in their specialty OR SUBSPECIALTY.

4. A minimum of three-fourths (¾) of the ALL members of WHO SERVE ON A SPECIALTY certifying boards must be in active ACTIVELY ENGAGED IN clinical practice, TEACHING PHYSICIANS, or an administrator SERVING IN AN ADMINISTRATIVE ROLE.

B. Term of Office

1. Members will be elected for terms of three (3) years. Where possible, terms will be staggered so that new members elected in any year will not constitute a majority of the board.
2. Boards will institute a maximum term limit of four (4) consecutive three (3) year terms or a total of twelve (12) years lifetime. A waiver may be granted by the AOA-BOT in extraordinary circumstances.

3. Whenever an unexpected vacancy occurs on the board, a nominee will be submitted to the BOS to fill the remaining term IN ACCORDANCE WITH THE PROCEDURE FOR CERTIFYING BOARD MEMBERSHIP (SECTION 2, A, 2). The BOS will submit a recommendation to the AOA-BOT who will make the final decision regarding the appointment.

4. All board members’ terms will commence on August 1 following approval by the AOA-BOT and end on July 31 of the year their term is scheduled to end.

5. Members of the board who have faithfully served three or more terms on the board may be given emeritus status in recognition of their service. Emeritus members may attend board meetings and events at their own expense unless they are examining candidates.

Section 3. Officers

A. Chair and Vice Chair

1. The Chair will make appointments to all board committees and will preside at all meetings of the board.

A. THE CHAIR OF THE BOARD ONLYCASTS A VOTE IN CASES WHERE THERE IS A TIE.

2. The Vice Chair will preside at all meetings of the board in the absence of the Chair and assist the Chair in the discharge of the duties of that office, which are outlined below:

a. Develop and maintain best practices for physician credentialing, AND certification, and OCC.

b. Ensure the delivery of relevant and osteopathically distinct examination processes and methodologies.

c. Facilitate board involvement in the achievement of key quality indicators for board performance and communicate progress against goals with AOA leadership, the BOS, and board members.

d. Develop and cultivate relationships with program directors and other officials in identifying, SERVE AS AMBASSADORS marketing, and preparing candidates for AOA BOARD certification WITH PROGRAM DIRECTORS, RESIDENTS, DIPLOMATES, AND OTHER STAKEHOLDERS.

e. Collaborate with the board director to oversee and monitor the AND PROVIDE FEEDBACK AND INPUT ON board specific marketing planS AND IDENTIFY OPPORTUNITIES FOR THE COMMUNICATION AND MARKETING OF SERVICES.

f. Collaborate with the board director to track diplomate performance and track compliance in meeting OCC requirements.

g. Serve as a subject matter expert for board level exam and item bank content.

h. Work with the VP-CBS to make sure budget targets are met and recommend adjustments as needed.

i. Collaborate with the board director to identify opportunities for the communication and marketing of services.

j. Recruit and develop new board members, subject matter experts, item writers, and other examiners as appropriate.
k. Collaborate with the SVP-CBS and other AOA team members to ensure the examination process advocated by the board is fiscally viable, appeals to the target demographic, and maintains high standards of defensibility.

B. Secretary
The secretary of the board will perform the duties as follows:

1. Coordinate with the board director, In issuing certificates and notifying the AOA and BOS of any changes in a physician’s certification status.
2. Coordinate with the board director in reporting any change in board membership to the Secretary of the BOS.
3. Participate in arranging examinations, recommending the dates and locations of all examinations. Examinations will be scheduled early enough so that the dates may be published no later than nine (9) months prior to the examination date, except in the case of individually arranged clinical examinations.
4. Coordinate with the board director to produce required reports to the BOS, including but not limited to the board’s candidate pass rate report.
5. Coordinate with the board director to prepare the required documentation for candidates who have completed requirements for certification.

Section 4. Subcommittees
Each board level subcommittee should have a prescribed set of duties and functions as determined by the board.

Section 5. Meetings
A. Boards should conduct business via video or telephone conference as much as possible.
   1. In-person meetings will be held in conjunction with the BOS symposia meetings.

B. Special Meetings
   1. Special meetings of the board that are deemed necessary for the transaction of business may be called by the Chair.

C. Quorum
   1. For the transaction of business at any meeting of the board, a majority of the members of the board shall constitute a quorum.

D. Governing Rules
   1. Meetings of the board shall be governed by the latest edition of Robert’s Rules of Order, Newly Revised, unless otherwise specified in these procedures.

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Article VIII. Certification

Section 1. Certification Pathways for Initial Certification (Not Previously Certified by AOA or ABMS)
To be eligible to receive certification from the AOA through member specialty certifying boards, the applicant must meet the following minimum requirements:
A. Osteopathic physicians
   1. Be a graduate of a COCA accredited College of Osteopathic Medicine. (B-07/15)
   2. Obtain training complete status from an ACGME/AOA accredited/approved residency training program.

B. Allopathic physicians – US and Canada Programs
   1. Be a graduate of a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME).
   2. Obtain training complete status from an ACGME residency program.

C. Allopathic physicians – Non US and Canada Programs
   1. Be a graduate of a medical school outside the United States and meet one of the following additional requirements:
      a. Hold a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or
      b. Have graduated from a medical school outside the United States and have completed a fifth pathway program provided by an LCME accredited medical school.
   2. Obtain training complete status from an ACGME residency program.

A. PATHWAY 1: AOA BOARD CERTIFICATION IN (SPECIALTY NAME)

B. PATHWAY 2: AOA BOARD CERTIFIED IN (SPECIALTY NAME) WITH OSTEOPATHIC MANIPULATIVE MEDICINE (OMM)

ELIGIBILITY CRITERIA:

A. PHYSICIANS WHO GRADUATED FROM A COCA ACCREDITED COLLEGE OF OSTEOPATHIC MEDICINE AND AN ACGME ACCREDITED PROGRAM ARE ELIGIBLE FOR BOTH PATHWAY 1 AND PATHWAY 2

B. PHYSICIANS WHO GRADUATED FROM A COCA ACCREDITED COLLEGE OF OSTEOPATHIC MEDICINE AND AN AOA ACCREDITED PROGRAM ARE ELIGIBLE FOR BOTH PATHWAY 1 AND PATHWAY 2

C. PHYSICIANS WHO GRADUATED FROM A MEDICAL SCHOOL IN THE U.S. OR CANADA ACCREDITED BY THE LIAISON COMMITTEE ON MEDICAL EDUCATION (LCME) OR HAVE GRADUATED FROM A MEDICAL SCHOOL OUTSIDE OF THE U.S. OR CANADA AND HOLD A VALID CERTIFICATE, WITHOUT EXPIRED EXAMINATION DATES, FROM THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG), AND HAVE COMPLETED AN ACGME ACCREDITED PROGRAM WITH OSTEOPATHIC RECOGNITION ARE ELIGIBLE FOR BOTH PATHWAY 1 AND PATHWAY 2

D. PHYSICIANS WHO GRADUATED FROM A MEDICAL SCHOOL IN THE U.S. OR CANADA ACCREDITED BY THE LIAISON COMMITTEE ON MEDICAL EDUCATION (LCME) OR HAVE GRADUATED FROM A MEDICAL SCHOOL OUTSIDE OF THE U.S. OR CANADA AND HOLD A VALID CERTIFICATE, WITHOUT EXPIRED EXAMINATION DATES,
FROM THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG), AND HAVE COMPLETED AN ACGME ACCREDITED PROGRAM WITHOUT OSTEOPATHIC RECOGNITION ARE ELIGIBLE FOR PATHWAY 1 ONLY.

E. PHYSICIANS WHO GRADUATED FROM A MEDICAL SCHOOL IN THE U.S. OR CANADA ACCREDITED BY THE LIAISON COMMITTEE ON MEDICAL EDUCATION (LCME) OR HAVE GRADUATED FROM A MEDICAL SCHOOL OUTSIDE OF THE U.S. OR CANADA AND HOLD A VALID CERTIFICATE, WITHOUT EXPIRED EXAMINATION DATES, FROM THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG), AND HAVE COMPLETED AN ACGME ACCREDITED PROGRAM WITHOUT OSTEOPATHIC RECOGNITION, BUT WHO HAVE OBTAINED AOA SPECIALTY BOARD AND BOS APPROVED TRAINING IN OMM MAY APPLY TO THE CERTIFYING BOARD FOR APPROVAL TO ENTER PATHWAY 1 OR PATHWAY 2.

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Article XIX. Osteopathic Continuous Certification

SECTION 6. ENTRY INTO OSTEOPATHIC CONTINUOUS CERTIFICATION (OCC) BY PHYSICIANS WITH CERTIFICATION FROM AN ABMS BOARD

PHYSICIANS HOLDING A CURRENT, VALID CERTIFICATION FROM AN AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS) MEMBER BOARD ARE ELIGIBLE FOR AOA BOARD CERTIFICATION AND TO ENTER THE AOA OSTEOPATHIC CONTINUOUS CERTIFICATION (OCC) PROCESS IN THE SPECIALTY FOR WHICH THEY HAVE ABMS CERTIFICATION. FOR ALL APPLICABLE PRIMARY AND SUBSPECIALTY CERTIFICATIONS FOR WHICH THE AOA OFFERS CERTIFICATION, ELIGIBILITY CRITERIA ARE AS FOLLOWS:

ELIGIBILITY CRITERIA FOR ENTERING TRADITIONAL, HIGH-STAKES OCC PRIMARY CERTIFICATION

PHYSICIANS HOLDING A CURRENT ABMS BOARD CERTIFICATION ARE ELIGIBLE FOR AOA BOARD CERTIFICATION AND WILL BE GRANTED RECIPROCITY OF THEIR CERTIFICATION UPON FULFILLING THE FOLLOWING CRITERIA:

• BE A GRADUATE OF A COCA ACCREDITED COLLEGE OF OSTEOPATHIC MEDICINE, AN LCME ACCREDITED MEDICAL SCHOOL IN THE U.S. OR CANADA, OR A MEDICAL SCHOOL OUTSIDE OF THE U.S. OR CANADA AND HOLD A VALID CERTIFICATE, WITHOUT EXPIRED EXAMINATION DATES, FROM THE ECFMG.

• CURRENT, VALID LICENSURE WITHIN THE UNITED STATES, OR THE U.S. TERRITORIES, OR THE DISTRICT OF COLUMBIA, OR CANADA.
• COMPLETION OF AN ACGME ACCREDITED RESIDENCY, FELLOWSHIP IN THE SPECIALTY OR SUBSPECIALTY OF CERTIFICATION, OR COMPLETION OF AN APPROVED CLINICAL PATHWAY TO CERTIFICATION.

• CURRENT, VALID (INCLUDING ACTIVE PARTICIPATION IN MAINTENANCE OF CERTIFICATION (MOC), IF APPLICABLE), VERIFIABLE BOARD CERTIFICATION THROUGH AN ABMS MEMBER BOARD IN A SPECIALTY OR SUBSPECIALTY FOR WHICH THERE IS AN EQUIVALENT AOA CERTIFICATION WITH AN ACTIVE OCC PROCESS.

• SUBMITTING A COMPLETED APPLICATION WITH ALL RELEVANT MATERIALS AND THE REQUIRED PROCESSING FEE.

SUBSPECIALTY CERTIFICATION

PHYSICIANS HOLDING A CURRENT ABMS SUBSPECIALTY CERTIFICATION ARE ELIGIBLE FOR AOA SUBSPECIALTY BOARD CERTIFICATION UPON FULFILLING THE FOLLOWING CRITERIA:

• SUBSPECIALTIES THAT CURRENTLY REQUIRE ACTIVE AOA PRIMARY CERTIFICATION (SEE APPENDIX L FOR A FULL LIST):
  o PHYSICIANS WHO DO NOT ALREADY HOLD AN ACTIVE AOA PRIMARY CERTIFICATION IN THE REQUIRED PRIMARY SPECIALTY MUST OBTAIN AN ACTIVE AOA CERTIFICATION IN THE PRIMARY SPECIALTY AS NOTED ABOVE, BEFORE APPLYING FOR ENTRY INTO THE OCC PROCESS.
    ▪ EXAMPLE: A PHYSICIAN MUST HOLD ACTIVE AOA PSYCHIATRY CERTIFICATION TO APPLY TO AOA SUBSPECIALTY CERTIFICATION FOR GERIATRIC PSYCHIATRY.
  o IF THE ABMS BOARD DOES NOT REQUIRE PRIMARY CERTIFICATION TO MAINTAIN CERTIFICATION IN THE SUBSPECIALTY, BUT THE AOA DOES REQUIRE PRIMARY CERTIFICATION IN ORDER TO MAINTAIN SUBSPECIALTY CERTIFICATION, THE PHYSICIAN WILL STILL BE REQUIRED TO HOLD ACTIVE AOA CERTIFICATION IN THE PRIMARY SPECIALTY. THE SAME PROCESS AS PREVIOUSLY DESCRIBED WILL APPLY.
    ▪ EXAMPLE: A PHYSICIAN WITH CURRENT SUBSPECIALTY CERTIFICATION IN SPORTS MEDICINE THROUGH THE AMERICAN BOARD OF INTERNAL MEDICINE (ABIM) MUST STILL OBTAIN A PRIMARY CERTIFICATION THROUGH THE AMERICAN OSTEOPATHIC BOARD OF INTERNAL MEDICINE (AOBIM) PRIOR TO ENTRY INTO AOBIM'S OCC PROCESS.

• SUBSPECIALTIES THAT DO NOT REQUIRE ACTIVE AOA PRIMARY CERTIFICATION (SEE APPENDIX M FOR A FULL LIST):
  o PHYSICIANS MAY APPLY FOR AOA SUBSPECIALTY CERTIFICATION WITHOUT HOLDING ACTIVE AOA PRIMARY CERTIFICATION.
    ▪ EXAMPLE: A PHYSICIAN MAY BECOME AOA BOARD CERTIFIED IN GASTROENTEROLOGY WITHOUT HOLDING ACTIVE AOA PRIMARY CERTIFICATION.
• BE A GRADUATE OF A COCA ACCREDITED COLLEGE OF OSTEOPATHIC
  MEDICINE, AN LCME ACCREDITED MEDICAL SCHOOL IN THE U.S. OR
  CANADA, OR A MEDICAL SCHOOL OUTSIDE OF THE U.S. OR CANADA
  AND HOLD A VALID CERTIFICATE, WITHOUT EXPIRED EXAMINATION
  DATES, FROM THE ECFMG.

• CURRENT, VALID LICENSURE WITHIN THE UNITED STATES, OR THE
  U.S. TERRITORIES, OR THE DISTRICT OF COLUMBIA, OR CANADA.

• COMPLETION OF AN ACGME ACCREDITED RESIDENCY, FELLOWSHIP
  IN THE SPECIALTY OR SUBSPECIALTY OF CERTIFICATION, OR
  COMPLETION OF AN APPROVED CLINICAL PATHWAY TO
  CERTIFICATION.

• CURRENT, VALID (INCLUDING ACTIVE PARTICIPATION IN
  MAINTENANCE OF CERTIFICATION (MOC), IF APPLICABLE),
  VERIFIABLE BOARD CERTIFICATION THROUGH AN ABMS MEMBER
  BOARD IN A SPECIALTY OR SUBSPECIALTY FOR WHICH THERE IS AN
  EQUIVALENT AOA CERTIFICATION WITH AN ACTIVE OCC PROCESS.

• SUBMITTING A COMPLETED APPLICATION WITH ALL RELEVANT
  MATERIALS AND THE REQUIRED PROCESSING FEE.

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
RES. NO. B-5 - A/2020– Page 1

SUBJECT: REVISIONS TO THE AOA ACCREDITATION REQUIREMENTS FOR AOA CATEGORY 1 CME SPONSORS

SUBMITTED BY: Bureau of Osteopathic Education/ Council on Osteopathic Continuing Medical Education

REFERRED TO: AOA Board of Trustees

WHEREAS, the COCME reviewed revisions to the AOA Accreditation Requirements for AOA Category 1 CME Sponsors for 2019-2021 at their October meeting; and

WHEREAS, the Council recommends some policy changes; now, therefore be it

RESOLVED, that the revised Accreditation Requirements for Category 1 CME Sponsors be APPROVED.

(Old material crossed out; new material in capital letters, moved material underlined)

Explanatory Statement:
Many of the revisions to the Accreditation Requirements for Category 1 CME Sponsors was re-organizing already existing standards. Those changes are underlined in the attached document.

FISCAL IMPACT: $0

<Reminder, a resolution with fiscal impact must be sent to the Finance Committee for their review and action.>

ACTION TAKEN _____________________

DATE _____________________
ACCREDITATION REQUIREMENTS FOR CATEGORY 1 CME SPONSORS

Section I. INTRODUCTION

WHO MAY APPLY

INSTITUTIONS MUST MEET THE FOLLOWING STANDARDS TO BE CONSIDERED FOR ACCREDITATION BY THE COUNCIL ON OSTEOPATHIC CONTINUING MEDICAL EDUCATION.

1. THE INSTITUTION MUST HAVE AN OSTEOPATHIC AFFILIATION:
   a. AOA affiliated divisional STATE societies AND THEIR COMPONENT SOCIETIES MUST BE CHARTERED BY THE AOA HOUSE OF DELEGATES
   b. AOA affiliated Specialty colleges AND THEIR COMPONENT SOCIETIES MUST BE CHARTERED BY THE AOA HOUSE OF DELEGATES
   c. Colleges of Osteopathic Medicine (including branch campuses) must have accreditation by the Commission on Osteopathic College Accreditation (COCA) and have graduated its first class or received pre-accreditation status by COCA
   d. Osteopathic non-practice affiliates (foundations, alumni groups, philanthropic organizations) MUST BE CHARTERED BY THE AOA HOUSE OF DELEGATES
   e. Healthcare facilities with osteopathically recognized GME MUST HAVE training programs THAT HAVE ACGME OSTEOPATHIC RECOGNITION

2. Complete and submit an application for CME accreditation, ALONG WITH AN APPLICATION FEE OF $2,500

Special Notes:
An accredited CME Sponsor may not transfer or assign its accreditation status to another entity. However, it may co-sponsor a Category 1 CME program with another agency, who will be termed “providers.” When co-sponsoring with a provider, it is the CME Sponsor’s responsibility to ensure that the program follows the AOA Category 1 CME requirements.

A CME Sponsor must make a new application for accreditation as a Category 1 CME Sponsor if it has a significant change in its organizational structure, including but not limited to the purchase, sale, divestiture, merger, or acquisition of the CME Sponsor. A change in the name of the CME Sponsor without other organizational changes is not considered a significant change in the organizational structure and does not require a new application. However, the CME Sponsor must notify the AOA COCME of such a name change.

The Board of Trustees of the American Osteopathic Association (AOA) is the only body entitled to establish accreditation policy for osteopathic CME Sponsors. The Council on Osteopathic Continuing Medical Education (COCME) as delegated by the AOA Board of Trustees is responsible for accrediting AOA Category 1 CME Sponsors, setting standards and procedures for accreditation of osteopathic CME Sponsors. The Council reports to the Bureau of Osteopathic Education.

Section II. STANDARDS OF ACCREDITATION QUALITY GUIDELINES FOR CME PROGRAMS

The purpose of these guidelines ACCREDITATION is to ensure that all programs presented by AOA-accredited Category 1 CME Sponsors are developed appropriately according to the planning, design, implementation and evaluation standards contained in this document.
The purpose of continuing medical education (CME) is to enhance the physician's ability to care for patients. It is the responsibility of the CME Sponsor of a CME activity to ensure that the educational activity is designed primarily for that purpose. Regardless of the support received from outside agencies, it is the responsibility of the CME Sponsor to ensure that programs adhere to the AOA Uniform Guidelines.

CME PROGRAMS MUST MEET THE FOLLOWING REQUIREMENTS:

A. Quality Guidelines CORE COMPETENCIES

All CME programs developed by CME Sponsors must address one or more of the AOA seven core competencies:

a. OSTEOPATHIC PHILOSOPHY AND OSTEOPATHIC MANIPULATIVE MEDICINE
b. MEDICAL KNOWLEDGE
c. PATIENT CARE
d. INTERPERSONAL AND COMMUNICATION SKILLS
e. PROFESSIONALISM
f. PRACTICE-BASED LEARNING AND IMPROVEMENT, AND
g. SYSTEM-BASED PRACTICE.

B. Needs Assessment PRACTICE GAP ANALYSIS

CME Sponsors shall systematically identify the CME needs PRACTICE GAPS of prospective participants and use that information in planning CME activities.

Needs Assessments PRACTICE GAP ANALYSIS must be:

a. Conducted on an annual basis for each REPEATED program.
b. Included for each presentation PRODUCED FOR EACH TOPIC
c. Based on current data and analysis
d. Documented with at least one evidenced-based source

Programs exempt from providing needs assessment PRACTICE GAP ANALYSIS include:

a. OMM/OMT/OPP – state that it is “part of the profession” in documentation.
b. PROGRAMS ADDRESSING NON-CLINICAL core competencies that are not clinical (professionalism, communications, systems based practices, etc) – state “Core competency required for specialty”
c. Faculty development programs
d. State LICENSURE requirements, such as risk management
e. Board preparation courses – state “based on pass rate on board scores”

Examples of needs assessment PRACTICE GAP ANALYSIS tools include:

a. Medical Audit (Identifying Needs)
   i. Develop criteria of excellence
   ii. Collect and summarize data
   iii. Analyze and interpret data
b. Pre-Test item analysis (Identified Needs)
c. Self-Assessment (Identified Needs and Physician Perceived Needs)
d. Questionnaire (Physician Perceived Needs)
C. EDUCATIONAL Objectives
CME Sponsors shall develop learning objectives, based on identified educational needs. GAPS IN KNOWLEDGE, for each CME event- TOPIC. The objectives shall state what the physician must have learned. KNOWLEDGE, SKILLS AND ATTITUDES ARE IMPACTED or mastered by the conclusion of the program such as the correction of outdated knowledge and acquisition of new knowledge in specific areas, the mastering of new skills, OR the changing of attitudes or habits, or other.

CME Sponsors shall use the objectives developed for an educational activity to select the content and design the educational methods for that activity. BLOOM’S TAXONOMY ACTION VERBS LIST IS AN EXCELLENT SOURCE FOR WRITING AND DEVELOPING LEARNING OBJECTIVES. HTTPS://TEACHINGCOMMONS.STANFORD.EDU/RESOURCES/COURSE-PREPARATION-RESOURCES/COURSE-DESIGN-AIDS/BLOOM%E2%80%99S- TAXONOMY-EDUCATIONAL-OBJECTIVES

D. Outcomes Measurement
CME Sponsors are required to conduct an Outcomes Survey after each event for AOA Category 1-A and Category 1-B CME programs. CME Sponsors shall send program attendees an outcomes survey no sooner than fourteen (14) days and no later than thirty (30) days following the conclusion of the program. Each Category 1-A sponsor may offer up to 3 additional 1-A credits at a ratio of 1:10 for each Category 1-A program in excess of 10 credits and one hour for each program less than 10 credits in which the participant satisfactorily completes an outcomes questionnaire. Programs that provide less than 5 Category 1-A or 1-B credits are exempt.

CME Sponsors can begin an Outcomes Survey at any time after an event ends but must conclude it no later than 30 days after the conclusion of the live events for which the Survey is been conducted. If the Sponsor wishes to monitor a longer change in learner behavior, they may also follow up with another survey after the initial survey. After participants complete the Survey and submit their answers, the CME credits should be reported by the CME Sponsor to the AOA. Sponsors have ninety (90) days after the event’s conclusion to report the credits.

An Outcomes Survey is required for OMM programs; but “exempt” from requiring a needs assessment.

The document survey process for reaccreditation shall include measures to evaluate compliance with CME and specialty credit requirements in reporting activities.

AN OUTCOMES MEASUREMENT OF THE EFFECTIVENESS OF A PROGRAM SHALL BE CONDUCTED. NO CME SHALL BE AWARDED FOR THIS ACTIVITY. THIS CAN BE CONDUCTED BY SURVEY FOLLOWING THE PROGRAM OR BY A SIMPLE QUESTION OR SERIES OF QUESTIONS SUCH AS “LIST AT LEAST ONE THING YOU LEARNED FROM THIS ACTIVITY” ; OR “WILL YOU IMPLEMENT ANYTHING LEARNED FROM THIS ACTIVITY INTO YOUR PRACTICE? IF SO, WHAT AND HOW? IF NOT, WHY NOT?” AS A COMPONENT OF YOUR PROGRAM EVALUATION.
E. COMMERCIAL SUPPORT

1. Funding Arrangements – The ultimate decision regarding funding arrangements for CME activities must be the responsibility of the CME Sponsor. Funds from a commercial source should MUST be in the form of an UNRESTRICTED educational grant for the support of programming and made payable to the CME Sponsor. The terms of the grant must be set forth in a written agreement.

There shall be no other funds paid to faculty, CME program directors, or others involved with the supported program except as provided in the written agreement. All support associated with educational activity must be made under the direction of, and with full knowledge and approval of, the CME Sponsor.

Payment of reasonable honoraria and reimbursement of out-of-pocket expenses for faculty is customary and proper. Commercial support must be acknowledged in printed announcements and brochures; however, reference must not be made to specific commercial products on (the program’s) MATERIALS signage or during the presentation. Following the CME activity, the CME Sponsor must be prepared to report to each commercial supporter, information concerning the expenditure of funds each has provided.

Commercial sources may not be involved in the program design, educational content, speaker selection, or as a provision for such funding.

2. Marketing CME Activities – A CME Sponsor may authorize a commercial supporter to disseminate information regarding the CME activity to the medical community. This may only be completed OCCUR with the express, written permission of the CME Sponsor stating the marketing material has been reviewed and approved for distribution. Any marketing material distributed regarding the CME activity must identify the CME Sponsor as the producer of the event.

3. Expenses for Attendees – Funds received from commercial support may not be used in any form to pay for the expenses of non-faculty attendees. The CME Sponsor may use commercial support as subsidies for hospitality or social events held as a part of the educational activity.

4. Program Design – When designing educational activities, the CME Sponsor must ensure the activities are:
   a. Free of bias for or against any commercial product. Designed and produced so that content and educational methods are ultimately determined by the CME Sponsor.
   b. If the program includes activities related to commercial products, objective information about the products must be incorporated in the program based on scientific methods generally accepted in the medical community.
   c. The design and production of educational activities shall be the ultimate responsibility of the CME Sponsor. Commercial supporters of such activities shall not control the planning, content or execution of the activity. This applies to:
      1. Preparation of educational materials – The content of slides and reference materials must remain the ultimate responsibility of the faculty of CME Sponsor.
      2. Educational Planning – A CME Sponsor must maintain responsibility and control over the selection of content, schedule, faculty, attendees, and educational methods and materials in all of its CME activities. A CME Sponsor may obtain information to assist in
planning and producing an educational activity from any outside source. To maintain
certainty, the CME Sponsor may not accept advice or services related to
educational content, speaker selection, or invites from a commercial entity. This type of
input may not be included in any agreement for commercial support.

5. Scholarships – Scholarships or other special funding to permit medical students, interns, or
residents and fellows to attend selected educational conferences may be provided BY
COMMERCIAL SUPPORTERS. However, the selection of candidates selected for scholarships
must be made by the academic or training institution, or by the CME Sponsor, with the full
concurrence of the academic or training institution.

6. Exhibits – When commercial exhibits are part of an overall program, arrangements for these
must not influence educational planning or interfere with the presentation of CME activities.
Exhibit placement must not be a condition of support for a CME activity. Exhibits at scientific
meetings are marketing, not educational, activities and are beyond the scope of the present
report. THERE MUST BE The physical separation of exhibits from conference rooms and
meeting halls in which teaching activities take place underscores the distinction between
education and marketing/promotional efforts. The AOA awards no CME credit for scientific
exhibits. Scientific poster displays cannot occur in the same room as industry exhibits if CME
credit is being awarded (i.e., to poster judges AND/OR attendees who view the posters).

No commercial promotional materials shall be displayed or distributed in the same room
immediately before, during, or immediately after an accredited educational activity APPROVED
FOR CREDIT. Representatives of commercial supporters may attend an educational activity for
which they have provided support, but may not engage in sales activities while in the room
where the educational activity takes place. PROMOTIONAL MATERIALS SHOULD NEVER
BE MIXED WITH AN EDUCATIONAL OFFERING.

7. Proprietary Names of Products – While the use of proprietary names of products is permissible
during educational activities, generic names should be used by the faculty whenever possible.
Moreover, it is the responsibility of the CME Sponsor to ensure presentations give a balanced
view of diagnostic, therapeutic, or appliance options. If proprietary names are used, those of
several companies that make relevant products must be used rather than only those of a single
company.

8. Disclosure – CME Sponsors shall have a policy requiring disclosure of any financial interest or
other relationship a CME faculty member or the CME Sponsor has with any commercial entities
discussed in the educational presentation.

Such faculty or CME Sponsor relationship with commercial entities shall be disclosed to
participants prior to educational activities in brief statements WITHIN the conference, such as
during the introduction of faculty, or in the faculty’s slide deck, OR IN DISSEMINATED
MATERIALS AND/OR ELECTRONIC COMMUNICATIONS INCLUDING WEB-
BASED AND APP-BASED CONFERENCE MATERIALS.

In the case of a regularly scheduled event, such as grand rounds, disclosure shall be made by the
moderator of the activity after consultation with the faculty member or a representative of the
9. Communicating Results of Scientific Research – An offer by a commercial entity to provide a presentation reporting the results of scientific research shall be accompanied by a detailed outline of the presentation, which shall be used by the CME Sponsor to confirm the scientific objectivity of the presentation. Such information must conform to the generally accepted standards of experimental design, data collection and analysis.

10. Off-Label Uses Of Products – When an off-label use of a product, or an investigational use not yet approved for any purpose is discussed during an educational activity, the CME Sponsor shall require the speaker to disclose that the product is not labeled for the use under discussion, or that the product is still UNDER investigation. Discussions of such uses shall focus on those uses that have been subject of objective investigation.

F. ADMINISTRATIVE REQUIREMENTS FOR CME SPONSORS

ADMINISTRATIVE RESPONSIBILITIES OF CME SPONSORS INCLUDE:

1. Mechanisms for Tracking attendance and maintaining audience ATTENDANCE records.

2. Ensuring appropriate facilities and equipment are provided to enable the faculty to teach effectively.

3. CME Sponsors must include the accreditation statement on their Marketing materials UTILIZING the following language shall be used for advertising AOA Category 1-A CME programs that have been approved by the AOA:

   The [name of CME Sponsor] is accredited by the American Osteopathic Association to provide osteopathic continuing medical education for physicians.

   The [name of the CME Sponsor] designates this program for a maximum of [number] AOA Category 1-A credits and will report CME and specialty credits commensurate with the extent of the physician’s participation in this activity.

4. CME Sponsors shall provide a signed attendance sheet from each attendee indicating EVIDENCE THAT THE PHYSICIAN ATTENDED THE EDUCATIONAL PROGRAM, INCLUDING the number of credits earned for each CME activity. CME Sponsors may also use an electronic attestation form with the participant’s signature as long as there is evidence the physician attended the educational program. EXAMPLES OF ADEQUATE EVIDENCE INCLUDE SIGNED (INCLUDING ELECTRONIC SIGNATURES) ATTESTATION FORMS OR ELECTRONIC CHECK-IN SOFTWARE OR APPS.

5. Advertising and promotion of CME activities must be carried out in a responsible fashion, clearly displaying the educational objectives of the activity; the nature of the audience that may benefit from the activity; the cost of the activity to the participant, the items covered by the cost; the amount of CME credit that can be earned in compliance with the AOA CME Guide; and the credentials of the faculty.
6. The participants must be provided with a certificate or some other document attesting to the satisfactory completion of the CME activity, at the end of the activity or upon request. THE CERTIFICATE CAN BE ACCESSED VIA AN ONLINE PORTAL.

7. The CME Sponsor must have a written grievance policy as well as mechanism for providing fee refunds.

8. The CME Sponsor must **insure** ENCOURAGE adequate program participant evaluation.

9. The Food and Drug Administration (FDA) has ruled that a CME Sponsor that demonstrates administrative hardship may allow a third party to handle the financial arrangements for a CME program. The AOA Board of Trustees determined that CME Sponsors having two (2) or fewer full-time equivalent staff would be considered as having administrative hardship (Resolution 26 (M/95)).

10. The CME Sponsor must MAKE SURE THAT THEIR PROGRAMS PLAN provide evidence of integrating INTEGRATES osteopathic principles and practice into the program.

11. Minimum credit requirements and determining CME credits.

   Programs must provide a minimum of 0.75 0.25 credits to be eligible for CME credit. CME credits will be applied in ¼ (0.25) hour CREDIT increments.

   Partial credits will be awarded as follows:

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<thead>
<tr>
<th>Length of Program in Minutes</th>
<th>Credits</th>
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<tbody>
<tr>
<td>10-23 (minutes)</td>
<td>0.25</td>
</tr>
<tr>
<td>24-37</td>
<td>0.50</td>
</tr>
<tr>
<td>38-53 52</td>
<td>0.75</td>
</tr>
<tr>
<td>53-69</td>
<td>1.00</td>
</tr>
</tbody>
</table>

Examples:
- 45 minutes would be awarded 0.75 CME credits
- 1 hour 9 minutes would be awarded 1.00 CME credits
- 1 hour 20 minutes would be awarded 1.25 CME credits

12. Repeat Activities – CME Sponsors offering educational activities that repeat essentially the same information each time must demonstrate that every iteration of that activity meets all of the provisions found in the AOA Uniform Guidelines. MEET AOA STANDARDS

G. FACULTY

At least 30% of the total educational credits must be presented by: (1) osteopathic physicians; (2) MDs, PhDs, other professionals with graduate degrees who hold a faculty appointment at a college of osteopathic medicine; (3) AOA staff or AOA component society staff who hold a graduate degree; or (4) clinical COM faculty. Moderators will not be considered faculty if they simply introduce speakers and their topics. To fulfill the definition of faculty, they must actively participate in the educational program.
The AOA Council on Osteopathic CME has been authorized by the AOA Board of Trustees to review and grant exemption from this requirement for any CME program sponsored by a CME Sponsor for whom the audience will consist largely of non-family practice physicians. Such review will occur only on a program-by-program basis. Exemption is solely at the discretion of the AOA Council on Osteopathic CME. A copy of the procedures for requesting this exemption may be obtained from the AOA Department of Education (Resolution 43 (A/94).

H. Online CME Programs

1. **AOA** Category 1 CME Sponsors have the right to use any CME platform to deliver their CME programming, WITH THE EXCEPTION THAT THEY CME Sponsors may not host CME programs on a pharmaceutical or device manufacturer's website. In addition to the accreditation requirements outlined in this document, CME programs provided online, through video transmission, e.g., a podcast, webinar, or through other electronic means must meet the following requirements:
   a. Advertising of any type must not be anywhere within accredited educational materials.
   b. The mention of specific products in the acknowledgement of commercial support must not appear in the program, even if they are not related to the program topic.
   c. The CME Sponsor must give full disclosure to the learner about its policy on privacy and confidentiality as it relates to the CME activities on the Internet.

5. The AOA has agreed not to sponsor any Category 1-A accredited continuing educational programs and that accredited CME programs sponsored by the AOA affiliated specialty colleges and AOA affiliated divisional societies set their own fees for CME on the Internet.

2. **Category 1-A Requirements for Online CME Programs** – Category 1-A credits may be earned from real time interactive CME or online, on-demand CME programs. To qualify for 1-A credit, online, on-demand CME programs must meet the current requirements in addition to the following requirements:
   a. CME programs shall be allowed to remain available for up to three years from the date of original posting as long as the sponsor ensures that the content is still up-to-date and accurate as determined by the AOA Category 1-A sponsor who produced the program.
   b. All CME programs must have a content expert available for any questions on content from CME participants during the life plus one week of the program. The content expert must answer participant questions within one week of an inquiry.
   c. AOA accredited sponsors are required to implement a general outcome measure of the enduring (online) program. ONLINE COURSES WILL REQUIRE THE PHYSICIAN TO COMPLETE AN “EVALUATION” IN A TEXT FIELD SUCH AS “LIST AT LEAST ONE THING YOU LEARNED FROM THIS ACTIVITY” OR "WILL YOU IMPLEMENT ANYTHING LEARNED IN THIS ACTIVITY INTO YOUR PRACTICE? IF SO, WHAT WILL YOU IMPLEMENT AND HOW?" UPON COMPLETION THE PHYSICIAN WILL RECEIVE THE CERTIFICATE OF COMPLETION AND CME CREDIT.

3. **Category 2-A Requirements for Online CME Programs** – Category 2-A credit will be awarded for interactive live CME activities that meet the additional requirements for interactive live CME activities, but does not meet the standards for osteopathic Category 1-A programs.
Examples include programs held by CME Sponsors that do not meet the osteopathic Faculty component guidelines, or internet live CME programs accredited by AMA or approved by the AAFP.

4. **Category 1-B Requirements for Online CME Programs** – CME Sponsors may provide Category 1-B credit through Internet on-demand activities or other on-demand activities provided through non electronic means with video & audio, audio only, or audio and slide deck webinars. These courses are typically programs that are available on an on demand schedule and are not a real-time, interactive simultaneous conference.

5. **REPORTING CREDIT FOR Online CME Programs** – The CME Sponsor of the program must provide the information to the AOA, with the category designation and number of CME credits requested. For reporting “on demand” online programs CME Sponsors have 90 days after the course closes to submit the FROM THE DATE OF PHYSICIAN COMPLETION OF THE PROGRAM TO REPORT EARNED CME credits to the AOA.

The AOA Council on Osteopathic CME reserves the right to evaluate each interactive CME Internet program and activity and to deny CME credit REQUIRE ITS REMOVAL FROM ANY PLATFORM at its discretion.

2.2 Utilize evidence-based medicine. Evidenced-based medicine includes:

a. A Needs Assessment for each subject area, unless included in one of the Needs Assessment exclusions.

b. A definition of anticipated targeted audience, including relevant subjects based on the needs assessment.

c. Stated and printed educational objectives.

d. Credentialed subject experts on topics presented.

e. Active audience participation when feasible. This could include question and answer sessions, hand-on learning labs, and other types of interactive sessions.

f. 

g. An outcome survey that is sent to all attendees no sooner than fourteen (14) and no later than thirty (30) days following the conclusion of the program.

h.

i. Provide a signed Faculty Disclosure form for all faculty members.

B. **Uniform Guidelines for Accrediting Agencies**

CME Sponsors are encouraged should include the osteopathic tenets and osteopathically recognized elements in programs such as: 1) communication – talking about the holistic approach; 2) developing – a follow-up plan with participatory guidance; 3) facilitating – techniques etc. to help connect patients on a road to better quality of activities of daily living; 4) guiding – looking at whole picture to diagnose and treatment; 5) healing — spiritual, emotional, musculoskeletal, medical; 6) influencing (provide the environment) — acting as a patient advocate and partner to better health; 7) modifying — how to help patient change/alter lifestyle and habits for better health; and 8) restructuring — putting a plan into action, be incorporated into programs to qualify for category 1-A.
C. Uniform Guidelines for CME Sponsors

2.1 Mission Statement—A written statement defining the purpose of the CME program identifying the intended audience, and expected outcomes. This statement should be adopted by the CME Sponsor’s governing body.

2.2 Management Support—A written statement verifying that the CME Sponsor has sufficient management procedures in place, including sufficient financial support to fulfill the mission of the defined program.

2.3 Joint Educational Activities—CME Sponsors partnering with unaccredited agencies must follow these Guidelines, regardless of programs presented.

2.4 Enduring Materials—Instructional material created in conjunction with a planned CME activity will be developed and administered according to these Guidelines.

2.10 Independence of CME Sponsors—

c. Distribution of Advertising—

D. Educational Standards and Practices

Needs Assessment forms are required for each program when submitted to the AOA Department of Education for consideration of AOA Category 1 accreditation.

E. Other Guidelines

SECTION III.

STANDARDS FOR OSTEOPATHIC CATEGORY 1-A PROGRAMS

In addition to the Quality Guidelines and AOA Uniform Guidelines set forth in this document, CME Sponsors requesting Category 1-A credit must meet the following standards:

3.5 The CME Sponsor will utilize qualified presenters who have appropriate credentials and experience; illustrate education competence, and thorough knowledge of the topic area.

3.6 The CME Sponsor must provide the AOA with the name and telephone number of the provider responsible for administration of Category 1-A CME activities.

3.8 Maintenance and availability of records of participation in CME activities must be adequate to serve the needs of participants and others requiring this information.

3.11 The CME Sponsor must ensure a sound financial base is established for any planned CME programs and activities. Budget planning for CME should be clearly projected. The program should not be presented for the sole purpose of profit.

3.12 Adequate supportive personnel to assist with administrative matters and technical assistance shall be available.

3.13 The CME Sponsor must provide a means of adequately monitoring the quality of faculty presentations.

3.15 Some formal educational programs co-sponsored by accredited osteopathic institutions and organizations may be eligible for Category 1-A credit, depending on individual circumstances.

3.18 Specialty credit is granted by AOA’s Certifying Boards, which must establish a CME advisory committee to monitor compliance with specialty guidelines.

a. Organizations, outside of the designated specialty affiliate, may petition the relevant specialty board to determine if specialty credit may be granted by this third party.

b. Physicians may petition the specialty certifying board’s CME Advisory Subcommittee on a case-by-case basis for exception.

3.19 CME Sponsors may give specialty continuing medical education if the presentation(s) are deemed acceptable as specialty CME that meet the following criteria:

1. Be presented by:
a. An AOA or ABMS board certified physician in the specialty topic being discussed. The only exceptions allowed are those listed in paragraph 1.b. below.

b. Other qualified professional as indicated below:

1) Foreign-trained physician and non-physician presenters may be reviewed by the specialty certifying board’s CME advisory committee on a case-by-case basis. The respective CME advisory subcommittee should document the criteria for granting an exception for such individuals.

2) Physicians currently participating in an AOA or ABMS accredited clinical or research fellowship program would be considered acceptable for specialty CME credit.

3) Individuals who are current faculty members of COCA or LCME accredited medical schools will be considered acceptable for specialty CME credit.

2. Cover topic(s) of concern to osteopathic physicians certified in the specialty for which specialty CME is sought.

Section V-III. POLICIES

Requirements of CME Sponsors

Mandatory Attendance at CME Sponsors Conference – Each CME Sponsor is required to attend the AOA CME Sponsors Conference at least once during every 3-year CME cycle AND/or required review of a COCME-generated webinar(s) for CME Sponsors. A CME Sponsor that does not attend at least one Conference OR PARTICIPATE IN THE REQUIRED WEBINARS during each CME cycle will forfeit its CME accreditation.

CME Sponsors, who: (1) are awarded one-year accreditation; (2) are on probation; (3) have achieved a score of 60-69% on their document survey, or (4) are a new CME Sponsor accredited by the Council on Osteopathic Continuing Medical Education, must attend the CME Sponsors Conference immediately following the awarding of such accreditation by the Council.

1. Annual Minimum Programming Requirements – Each CME Sponsor must produce at least one 3-credit program or series within its accreditation cycle to retain its status as a CME Sponsor.

A program of 3 credits is defined as: (1) one 3-hour program; or (2) a series of lectures that total 3 credits. A series of lectures of 3 hours in length must have a single theme and must respond to a specific educational needs assessment GAP ANALYSIS.

An accreditation cycle is determined by the length of time a CME Sponsor has been awarded accreditation based on the score achieved, as outlined in section 8.2.

2. Reporting CME Activities – ALL AOA ACCREDITED CME Sponsors must ARE REQUIRED TO submit a roster of physician attendees for every CME event. Rosters will include the CME Sponsor’s name, event name, date and location, the name of each physician, their AOA numbers (if applicable), and the number of CME credits granted per physician attendee DATA ABOUT THEIR ACTIVITIES AND PROGRAM IN THE TRACME PLATFORM. CME Sponsors have up to 90 days following the completion of the program to submit the event roster to the AOA with CME and applicable specialty credits ENTER THE DATA.
3. CME Sponsor Accreditation and Registration Fees – CME Sponsors are assessed both accreditation and registration fees. The AOA Board of Trustees establishes both fees.

   a. Annual Accreditation Fee – The annual accreditation fee for each AOA-accredited CME Sponsor is $200.00.

   b. Program Registration Fees – CME Sponsors are responsible for the registration fee for the recording of physician credit hours. There is no program fee for recording outcomes measurement CME credit.

      i. Registration Fee Schedule for Colleges of Osteopathic Medicine – The fee for recording Category 1-A credit for colleges of osteopathic medicine is $25.00 per program conducted and $0.10 per credit reported, up to a maximum of $1,500.00 per year.

         The fee for recording Category 1-B credit for colleges of osteopathic medicine is $3,125.00 per year. Colleges may submit an unlimited number of Category 1-B credits under this fee. A college may petition for relief of the $3,125.00 per year fee for Category 1-B.

      ii. Registration Fee Schedule for Hospitals – The fee for the recording of unlimited Category 1-A and Category 1-B credits for hospitals is $1,250.00 per year.

      iii. Registration Fee Schedule for Specialty Colleges, Divisional Societies, Practice Affiliates, THEIR COMPONENT SOCIETIES and Osteopathic Foundations – The fee for recording Category 1-A and/or 1-B credit for specialty colleges, divisional societies, practice affiliates, and osteopathic foundations is $25.00 per program conducted, and $0.10 per credit reported, up to an maximum of $1,500.00 per year.

      iv. Exemption of Registration Fees – The Council on Osteopathic Continuing Medical Education may exempt certain currently approved program areas from the Category 1-B fees. Exempt areas at this time are scientific papers, publications, the conduct of healthcare facilities inspections, and the preparation of specialty board exams.

   c. Withholding the Recording of CME Credit – The AOA reserves the right to withhold the registration of CME credit for CME Sponsors which fail to pay their annual fees within 90 days of receipt of the annual invoice.

   d. On-site survey Expenses – Sponsors will be billed for the direct cost of on-site surveys.

4. Record Retention of the CME and Accreditation Programs – An AOA accredited CME Sponsor must maintain its files for a minimum of 6 years and at least two full 3-year CME cycles.
Section VI. Document Survey Procedure

1. Prior to the end of a CME Sponsor’s term of accreditation, the AOA Department of Education will review a listing of CME programs and select the appropriate program(s) for review.

2. The AOA will then notify the CME Sponsor of the program(s) chosen for review via electronic email and will ask the organization to submit the required information within thirty (30) working days of notification.

3. CME Sponsors may submit document survey requirements electronically, but the documents must be organized and formatted in accordance to the “Document Survey Evaluation Methodology” form as requested by the AOA.

4. The requested information will be reviewed by the AOA Department of Education and the results of this review will be forwarded to the Council on Osteopathic CME (“Council”) to determine the accreditation status of the CME Sponsor at the next Council meeting.

5. If the Council determines that serious quality problems exist, the Council has the option of notifying the CME Sponsor that it must respond to the cited deficiencies with a plan of corrective action. CME Sponsors will be notified of the need to submit missing documentation and will have ten (10) working days to submit missing information before any points are taken away.

6. Failure to submit the required documentation, or failure to respond to deficiencies within 30-working days may result in an on-site visit and survey and/or the initiation of procedures that would lead to the loss of AOA Category 1 CME Sponsor Accreditation status.

7. If a CME Sponsor requests an extension of more than 40 days, only up to 4 years of accreditation may be awarded. THEIR ACCREDITATION STATUS WILL BE REDUCED BY ONE (1).
Section V. Document Survey Evaluation Methodology

The Council uses the following checklist to evaluate the document survey. Points are awarded when the items are clearly marked in the document survey.

A CME Sponsor who achieve a perfect score of 100 points on the document survey and collect outcomes data on their CME programs, will be awarded “Accreditation with Commendation.”

<table>
<thead>
<tr>
<th>Checklist Items</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A description of the needs assessment PRACTICE GAP ANALYSIS process and procedure used in determining the content and topic of the program (include any supporting documents). (Major)</td>
<td>8</td>
</tr>
<tr>
<td>2. A copy of the CME program brochure or agenda distributed to participants at the CME program. (MINOR) TO VALIDATE THE FOLLOWING SPEAKER INFORMATION:</td>
<td>4</td>
</tr>
<tr>
<td>3. A) Copies of all program speakers’ (in chronological order) curriculum vitae or bio-sketch defining their qualifications for involvement in the CME program. (MAJOR). Partial credit is awarded based on the percentage of CVs and bio-sketches provided during the document survey review. (e.g., 5 CVs provided from a total of 10 speakers yields 4 points) All fractions are rounded down. (Major)</td>
<td>8</td>
</tr>
<tr>
<td>3. A) Less than 50% - 0.50% 4.90% 0.89 - 4.100% - 8</td>
<td></td>
</tr>
<tr>
<td>3. B) A copy of each speaker’s Disclosure Declaration Statement in chronological order. Partial credit is awarded based on the percentage of the disclosure statements provided during the document survey. (Major)</td>
<td>8</td>
</tr>
<tr>
<td>3. B) Less than 90% - 0 90% - 4</td>
<td></td>
</tr>
<tr>
<td>5. A copy of the CME credits requested ENTERED INTO TRACME by the CME Sponsor for each participating physician in accordance with the attestation document and specialty credits. TO VERIFY THAT THE DATA WAS ENTERED INTO TRACME AND REPORTED WITHIN THE 90 DAYS’ TIME LIMIT. (Minor)</td>
<td>4</td>
</tr>
<tr>
<td>6. A copy of the program administration evaluation document and the total number of evaluation documents returned by conference attendees. Provide two copies of the program evaluation documents that were returned by conference attendees, or a completed electronic evaluation/ PROVIDE AN OVERALL summary OF THE COMPLETED EVALUATIONS FOR THAT PROGRAM. (Minor)</td>
<td>4</td>
</tr>
<tr>
<td>7. A statement indicating the total number of attendees, and the number of attestation forms returned by conference participants MUST BE PROVIDED THIS WILL BE COMPLETED WITH THE DATA ENTERED INTO TRACME. ERRORS WILL RESULT IN ZERO POINTS. (Major MINOR)</td>
<td>8.4</td>
</tr>
<tr>
<td>7. A statement reflecting the distribution of program evaluation documents MUST BE PROVIDED (e.g., The beginning of the program, random survey, etc.) (Minor)</td>
<td>4</td>
</tr>
<tr>
<td>8. A policy statement on managing grievances relative to the returned program administration and evaluation document(s). (Minor)</td>
<td>4</td>
</tr>
</tbody>
</table>
498. A copy of the program outcomes questionnaire and the total number of outcomes questionnaire documents returned by conference attendees. Provide two copies of the outcomes questionnaire documents that were returned by conference attendees, or a completed electronic evaluation/summary. (MINOR) (Within 14 days and no later than 30 days). AN OUTCOMES MEASUREMENT OF THE EFFECTIVENESS OF A PROGRAM SHALL BE CONDUCTED. NO CME SHALL BE AWARDED FOR THIS ACTIVITY. THIS CAN BE CONDUCTED BY SURVEY FOLLOWING THE PROGRAM OR BY A SIMPLE QUESTION OR SERIES OF QUESTIONS SUCH AS “LIST AT LEAST ONE THING YOU LEARNED FROM THIS ACTIVITY”; OR “WILL YOU IMPLEMENT ANYTHING LEARNED FROM THIS ACTIVITY INTO YOUR PRACTICE? IF SO, WHAT AND HOW? IF NOT, WHY NOT?” AS A COMPONENT OF YOUR PROGRAM EVALUATION. (MINOR)

| 499A. Provide needs assessment PRACTICE GAP ANALYSIS per program topic. (MAJOR) Partial credit is awarded. 4 |
| 499B. A statement relative to how topics and/or speakers were selected in direct response to needs assessment PRACTICE GAP ANALYSIS procedures. (Minor) 4 |

4210. If the program was commercially supported, the following additional items must be submitted:

A) A copy of the formal written agreement between the CME Sponsor and each Commercial Supporter reflecting that activity (program) is educational and not promotional. WRITTEN AGREEMENT MUST ADHERE TO AOA STANDARDS FOR COMMERCIAL SUPPORT (Major) Partial credit is awarded. Less than 90 90% 4

B) Proof that commercial support is appropriately acknowledged in any printed promotional materials. (Minor) 4

C) A brief statement regarding all funding arrangements, include how funds received from commercial supporters were expended, how speakers were paid, i.e., if speakers were directly funded by a third party agent (someone besides the AOA CME Sponsor/Provider); Attach copy of the funding arrangement between the CME Sponsor and the third party agent. (Major) Partial credit is awarded. Less than 90 90% 4

A statement indicating how disclosure of potential conflict of interest regarding each speaker was given to the participants. (Major) Partial credit is awarded. Less than 90 90% 4

Total Score 100

The Council on Osteopathic Continuing Medical Education will award accreditation based on the following document survey scores:

Scoring Key:
Major – 8-12 points; Minor – 4 points (Total of 100 points)
Accreditation:

• 100 points on the document survey (first attempt) is awarded 5 years continuing accreditation with Commendation; 100 points on the document survey (after additional missing material is submitted to the AOA) is awarded 5 years continuing accreditation.

• 96-97-99 points on the document survey is awarded 5-year accreditation.

• 90-95 points on the document survey is awarded 4-year accreditation.

• 85-89 points on the document survey is awarded 3-year accreditation.

• 80-84 points on the document survey is awarded 2-year accreditation.

• 70-79 points on the document survey is awarded 1-year accreditation.

• 60-69 points on the document survey is awarded 1-year accreditation with required review of a COCME-generated webinar(s) for CME Sponsors AND ATTENDANCE AT NEXT SCHEDULED SPONSOR’S CONFERENCE.

• Less than 60 points on the document survey accreditation is withdrawn.
Section VIII. Accreditation

1. Accreditation Status of New Programs – Newly accredited CME Sponsors will be awarded 1-year accreditation. At the end of the first year, the CME Sponsor must submit a document survey to the Council on Osteopathic CME.

2. Accreditation Actions – The Council on Osteopathic CME shall evaluate the document survey using the checklist. The Council shall award accreditation based on the score achieved on the checklist AS NOTED.

   a. 100 points on the document survey (first attempt) is awarded 5 years continuing accreditation with Commendation; 100 points on the document survey (after additional missing material is submitted to the AOA) is awarded 5 years continuing accreditation.
   b. 96-99 points on the document survey is awarded 5 year accreditation;
   c. 90-95 points on the document survey is awarded 4 year accreditation;
   d. 85-89 points on the document survey is awarded 3 year accreditation;
   e. 80-84 points on the document survey is awarded 2 year accreditation;
   f. 70-79 points on the document survey is awarded 1 year accreditation;
   g. 60-69 points on the document survey is awarded 1 year accreditation, with required review of a CCME-generated webinar(s) for CME Sponsors;
   h. Less than 60 points on the document survey accreditation is withdrawn.

Probation – A CME Sponsor shall be placed on probation if it is awarded 1-year accreditation for three (3) years in a row. For CME Sponsors on probation, the Council on Osteopathic CME may choose to require an on-site survey and/or require the CME Sponsor to attend a Council meeting to discuss their accreditation status. The Council on Osteopathic CME has the authority to revoke accreditation for any CME Sponsor on probation if the information obtained at either the on-site survey or council meeting does not justify continued accreditation status. (The CME Sponsor on probation is responsible for all costs associated with an on-site survey or attendance at a council meeting.)

The Council on Osteopathic CME has the authority to place a CME Sponsor on probation if that CME Sponsor is found in GROSS violation of the AOA Uniform Guidelines ACCREDITATION STANDARDS.

Revocation WITHDRAWAL of Accreditation Status – The Council on Osteopathic CME has the authority to revoke WITHDRAW A Category 1 CME Sponsor’s accreditation status if a CME Sponsor is found in violation of the AOA Uniform Guidelines SCORE IS LESS THAN 60 POINTS ON THE DOCUMENT SURVEY. ALSO, IF FAILURE TO RESPOND TO DEFICIENCIES CITED IN AN ON-SITE SURVEY WITHIN THE 60 DAYS OF NOTICE AFTER COMPLETION OF THE ON-SITE SURVEY.
Section IX VII. Complaints

Complaints made against CME Sponsors are taken very seriously by the Council on Osteopathic Continuing Medical Education (COCME). CME Sponsors found to be out of compliance may be required to: (1) undergo an on-site visit, (2) attend a Council meeting to discuss a plan of corrective action, (3) be placed on probation, (4) be denied accreditation status, or (5) other action as approved by the Council.

1. Initial Complaint Review Procedure – A complainant shall first seek to resolve the problem directly with the CME Sponsor. If the complainant is unable to reach an agreeable solution to the grievance through the CME Sponsor, the responsibility for filing a formal complaint to the AOA Council on Osteopathic CME remains with the complainant. The CME Sponsor shall notify the complainant of this option.

2. Formal Complaint Procedure – The complainant shall submit a complaint in writing to the Council on Osteopathic CME. The complainant must identify the standard or standards alleged to be violated. The complainant must produce evidence that an effort has been made to resolve the problem with the CME Sponsor. The complainant shall include information about all other actions initiated to resolve the problem(s).

The Secretary of the Council on Osteopathic CME will forward all material to the CME Sponsor for response. The CME Sponsor has 30 days in which to respond to the written allegations.

The information received from the CME Sponsor will be forwarded to the Chair of the Council on Osteopathic CME for review. The Chair will determine which review body will be assigned to review the complaint. The Chair may select the Administrative Committee of the Council, or call a special subcommittee to review the complaint. In the event the Chair has a conflict of interest, the Vice-Chair shall select the review body. In the event the Vice-Chair has a conflict of interest in the matter, the Chair of the Bureau of Osteopathic Education shall select the review body.

3. Actions of the Review Body – The review body may take any of the following actions:

a. Dismiss – The review body may dismiss the complaint if it concludes that the CME Sponsor is in compliance with CME standards.

b. Postpone – The review body may postpone action on the complaint if there is evidence that the CME Sponsor in question is making responsible progress in rectifying the situation that warranted the complaint. If a postponement is made, the matter must come before the Council on Osteopathic CME within one year from the time of postponement for final resolution.

c. Probation – Based on the evidence, the review body may conclude that the CME Sponsor is failing to meet the CME standards. The review body may recommend to the Council that the CME Sponsor be placed on probation.
d. The CME Sponsor will be notified if the review body plans on recommending this action to the Council. The CME Sponsor may appear at the Council on Osteopathic CME meeting to present the sponsor’s perspective.

c. Withdrawal of Accreditation – Based on the evidence, the review body may conclude that CME Sponsor has failed to meet the CME standards. The review body may then recommend to the Council on Osteopathic CME that the accreditation of the CME Sponsor be withdrawn. The CME Sponsor will be notified if the review body plans on recommending this action to the Council. The CME Sponsor may appear at the Council on Osteopathic CME meeting to present the sponsor’s perspective.

Section X VIII. Reconsiderations and Appeals

1. CME Sponsors may request a reconsideration of an accreditation action by the Council on Osteopathic Continuing Medical Education (COCME) or appeal to the Bureau of Osteopathic Education.
   a. A request for reconsideration or a request for appeal will include a detailed description of errors in fact from the survey report, and the documentation of correction of noncompliance.
   b. The reconsideration/appeal procedures permit the CME Sponsor to show that it has corrected or is attempting to correct deficiencies that were found at the time of survey.
   c. Presentation of such corrections does not bind the Council on Osteopathic CME or the Bureau of Osteopathic Education to either reverse or accept the initial recommendations of the Council on Osteopathic CME.
   d. CME Sponsors requesting appeals will maintain their current accreditation status until the appeal hearing has been conducted, recommendations made, and acted upon by the AOA Bureau of Osteopathic Education.

2. Requests for reconsideration must be made in writing to the Council on Osteopathic CME, and must be filed within 30 days following receipt of the recommendation of the Council on Osteopathic CME.

3. Requests for appeal must be made in writing to the Bureau of Osteopathic Education, and must be filed within six (6) months of receipt of the action by the Council on Osteopathic CME. CME Sponsors must submit a $2,500 appeal fee with the formal written appeal request.

   Appeal fees do not apply to individual requests from students or physicians, including trainees. Should the BOE Appeal Committee overturn a decision from one of the education councils, half the application fee ($1,250) will be returned to the appellant, whether the decision was fully or partially over-turned.

4. CME Sponsors may seek a final appeal and hearing before the AOA Board of Trustees.
Section XIX On-Site Program Survey

1. Special reviews or complaint reviews may require an on-site survey. The total cost of this on-site program survey will be borne by the CME Sponsor being surveyed and billed through the AOA.

2. When on-site program surveys are scheduled, the CME Sponsor will be advised in writing of the date of survey.

3. A notification letter to the CME Sponsor will be sent at least six (6) weeks prior to the date of the on-site survey. (See Appendix E)

4. On-site Program Surveys will be conducted by AOA approved surveyors.

5. The AOA will maintain a list of surveyors approved annually by the Council on Osteopathic CME.

6. CME Sponsor program surveyors must submit written reports within 30 days to the Council on Osteopathic CME on all on-site sponsors/programs surveyed. A MEMBER FROM THE COUNCIL WILL SERVE AS A SURVEYOR.

7. Within 60 days after completion of the on-site survey of the CME Sponsor/program, the AOA Department of Accreditation will notify the CME Sponsor of any areas of noncompliance by certified mail.

8. CME Sponsors are required to respond formally with a plan of corrective action addressing all identified areas of noncompliance within 60 days of notice. Failure to respond to deficiencies cited may result in withdrawal of accreditation.

9. The Council on Osteopathic CME will evaluate survey reports of both document and on-site program surveys at its meetings.

10. CME Sponsors will be notified by certified mail of actions taken by the Council on Osteopathic CME, usually within ten (10) working days after its meeting.
Appendix A: Application Form for Category 1 Sponsor Accreditation

Instructions for Completing Category 1 Sponsor Accreditation Application Form

The attached form should be completed in duplicate. Forward the original copy to the AOA, Department of Education, 142 E. Ontario St., Chicago, IL, 60611-2864. Retain the duplicate copy for your records.

The AOA Council on Osteopathic CME requests that each item be answered as completely, yet concisely, as possible. Please be sure the form is signed and dated.

The Council on Osteopathic CME will accredit those organizations who meet the criteria established and printed in the Accreditation Requirements for AOA Category 1 CME Sponsors and in the AOA CME Guide. Please consult these documents prior to submission of this application form.

American Osteopathic Association
Department of Education
Accreditation Application for AOA Category 1 CME Sponsor

Part 1: General Information

1. Name of Organization __________________________________________________________

   Address ________________________________________________________________

   City ___________________________ State _________ Zip Code _________

2. Contact Person _____________________________________________________________

   Title _________________________________________________________________

   Phone ___________________________ Ext _________________________________

   Fax ____________________________ Email _________________________________

3. Type of Sponsor WHO MAY APPLY:

   A) _____ Healthcare Facilities with osteopathically-recognized GME training programs

   B) _____ College of Osteopathic Medicine accredited by COCA and graduated it first class or received pre-accreditation status by COCA

   C) _____ College of Osteopathic Medicine Branch Campus

   D) _____ Osteopathic Specialty College AND THEIR COMPONENT SOCIETIES

   (Practice Affiliate)

   E) _____ Osteopathic Specialty Board

   EE) _____ State Osteopathic Medical Association AND THEIR COMPONENT

   SOCIETIES (Divisional Society)

   GF) _____ Osteopathic Alumni Group, Osteopathic Philanthropic organization, or

   Osteopathic Non-practice Affiliate

   H) _____ Component Societies
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1. Attach a dated and signed copy of sponsoring organization CME mission statement indicating formal approval by sponsoring organization's board of trustees.

2. List on the attached form the CME programs/activities contemplated by the sponsoring organization for the coming year.

3. Indicate which, if any, programs/activities may be supported to some extent by commercial interests.

4. Indicate topic areas and commercial companies from which commercial support is anticipated with the type and the estimated dollar value of that support.

5. Indicate the type of commercial support you anticipate for your programs/activities by checking all appropriate boxes.
   a. _______ Funding
   b. _______ Materials supplied
   c. _______ Product information
   d. _______ Speaker
   e. _______ Other

6. Give an estimated percentage of total costs of the CME programs to be covered by commercial support.
   _______ % (estimate)

7. Does your organization conduct CME programs through joint sponsorship with other organizations?
   _______ Yes
   _______ No

8. Attach with this form the following:
   a. A program administration and evaluation document.
   b. The applicant policy on advertising and promotion.
   c. An outline of the applicant method of maintaining records.
   d. The means used by the applicant to certify CME participation by physicians.
   e. A policy on managing fee grievances and refunds.

9. Submit the above items along with the established fee to:
   American Osteopathic Association
   Department of Education
   142 E. Ontario St.
   Chicago, IL 60611-2864

   Signed
   ________________________________
   Authorized sponsoring organization representative

   Title: ________________________________

   Date: ________________________________
American Osteopathic Association
Department of Education
Accreditation Application for AOA Accredited Category 1 CME Sponsor

Part 2

Sponsoring Organization_________________________________________________________

Anticipated CME programs/activities for the Coming Year

<table>
<thead>
<tr>
<th>Programs/Activities</th>
<th>Date of Activity</th>
<th>General Topic</th>
<th>Name of Commercial Supporter(s)</th>
<th>Projected $ Support</th>
</tr>
</thead>
</table>

FOR OFFICE USE ONLY

Date Appl Recd

Approval Date

Code #
Appendix B: Sample Information

These are meant to be neither all-encompassing nor exclusionary.

Sample Bio-sketch:

John C. Jones, DO, FAAP will speak on “Attention Deficit Hyperactivity Disorder (ADHD).” He is a graduate of the University of Olympia and the Atlanta College of Osteopathic Medicine. He is Board certified in Pediatrics. Dr. Jones completed an internship at Suburban Hospital, Boise, Montana, and a residency in Pediatrics at Children’s Hospital, Oregon, Indiana. He currently practices at ABC Pediatric Hospital and Clinic. He is a fellow of the American College of Pediatrics, and is a member of the American College of Osteopathic Pediatricians.

Sample Evaluation Document:

Cardiology  
Wednesday, April 28, 1:00 – 5:30 p.m. Ballroom A

Name ______________  
AOA #______________

<table>
<thead>
<tr>
<th>Please rate the following</th>
<th>Excellent</th>
<th>Good</th>
<th>Satisfactory</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value of subject</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of speakers</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Knowledge of subject</td>
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<tr>
<td>Program length</td>
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<td></td>
</tr>
<tr>
<td>Presentation style</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response to questions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please write any comments on this session on the back of this sheet.

Sample Grievance Policies:

Sample Grievance Policy 1:

All grievances should be in writing and specify the nature of the grievance and any “particulars.” Initially, all grievances should be directed to the educational committee.

If the participant does not receive a satisfactory response, they may then notify the Council on Osteopathic Continuing Medical Education of the AOA at: 142 E. Ontario St., Chicago, IL 60611-2864.
Sample Grievance Policy 2:

Grievances shall be submitted in writing to the executive director or educational program chairperson. All grievances will receive an initial response in writing within 30 days of receipt.

The Executive Director will review all grievances and resolve if possible. If no resolution is possible, the Executive Director may then pass the information on to the President of the Association for resolution.

If the President is unable to resolve the grievance he may then pass the grievance on to the Executive Committee of the Board of Trustees and if no resolution can be made the grievance will then be presented to the full Board of Trustees.

Further appeals shall be addressed to the Council on Osteopathic Continuing Medical Education of the AOA at: 142 E. Ontario St., Chicago, IL 60611-2864.
Appendix C: Sample Commercial Support Form

Letter of Agreement Regarding Terms, Conditions and Purposes of an Educational Grant

Between ____________________ (Accredited Sponsor) and _________________ (Company)

Title of CME Activity _______________________________________________________

Location________________ Date(s) ____________________________________________

Company (name/Branch) ______________________________________________________

Address _____________________________________________________________________

City, State, Zip ______________________________________________________________

Telephone __________ Fax ____________ Contact Person __________________________

The above Company wishes to provide support for the named continuing medical education activity by means of (indicate which option):

1. Unrestricted PROVIDING AN UNRESTRICTED educational grant for support of the CME activity YES____ OR NO____

2. In the amount of $ _______

2. Restricted grant to reimburse expenses for:

   A. 1) __________________________________________________________
   2) __________________________________________________________

       To include all Expenses_____ Travel Only_______ Honorarium Only________

   (Honorarium Amount to be determined by Course Director)

   B. Support for catering functions (specify) ______________________________________

       in the amount of $ ___________________________ (see 10.d. on the back of this agreement)

   C. Other (e.g. equipment loan, brochure distribution, etc.) _____________________________

CONDITIONS

1. Statement of Purpose: program is for scientific and educational purposes only and will not promote the Company's products, directly or indirectly.

2. Control of Content & Selection of Presenters & Moderators: AOA Accredited Category 1 CME Sponsor (“Accredited Sponsor”) is ultimately responsible for control of content and selection of presenters and moderators. Company, or its agents, will respond only to Accredited SponsorS, who will disclose financial or other relationships between Company and speaker, and will provide this information in writing. Accredited Sponsor will record role of Company, or its agents, in suggesting presenter(s); will seek suggestions from other sources, and will make selection of presenter(s) based on balance and independence.

3. Disclosure of Financial Relationships: Accredited Sponsor will ensure disclosure to the audience of (a) Company funding and (b) any significant relationship between the Accredited Sponsor and the Company (e.g. grant: recipient) or between individual speakers or moderators and the Company.

4. Involvement in Content: there will be no “scripting,” emphasis, or influence on content by the Company or its agents.
5. Ancillary Promotional Activities: no promotional activities will be permitted in the same room or obligate path as the educational activity. No product advertisements will be permitted in the program room.

6. Objectivity & Balances: Accredited Sponsor will make every effort to ensure that data regarding the Company's products (or competing products) are objectively selected and presented, with favorable and unfavorable information and balanced discussion of prevailing information on the product(s) and/or alternative treatments.

7. Limitations of Data: Accredited Sponsor will ensure, to the extent possible, disclosure of limitations of data, e.g., ongoing research, interim analyses, preliminary data, or unsupported opinion.

8. Discussion of Unapproved Uses: Accredited Sponsor will require that presenters disclose when a product is not approved in the United States for the use under discussion.

9. Opportunities for Debate: Accredited Sponsor will ensure opportunities for questioning or scientific debate.

10. Independence of Accredited Sponsor in the use of Contributed Funds:
   a. Funds should be in the form of an educational grant made payable to __________________________ (Accredited Sponsor).
   b. All other support associated with this CME activity (e.g., distributing brochures, preparing slides) must be given with the full knowledge and approval of __________________________ (Accredited Sponsor).
   c. No other funds from the Company will be paid to the program director, faculty, or other involved with the CME activity (additional honoraria, extra social events, etc.).
   d. Funds may be used to cover the cost of one or more modest social activities held in conjunction with the educational program, which furthers the CME educational experience and/or allows an educational discussion and exchange of ideas. If Company sponsors a social event, the requirements set forth in Sections 1, and 3-5 will still apply.

The Company agrees to abide by all requirements of the AOA Guidelines for Relationships between Accredited Sponsors and Company of CME.

The Accredited Sponsor agrees to: 1) abide by the AOA Guidelines for Relationships between Accredited Sponsors and Company of CME; 2) acknowledge educational ACTIVITY support from the Company in program brochures, syllabi, and other program materials, and 3) upon request, furnish the Company a report concerning the expenditure of the funds provided.

AGREED
Company Representative (name) ____________________________________________Date________________
Signature__________________________________________________________
Course Director (name)______________________________________________Dept________________
Signature__________________________________________________________Date________________
CME Department Director or Designee (name)______________________Date________________
Signature__________________________________________________________Date________________
Appendix D: Faculty Disclosure Form

Faculty Disclosure Declaration

It is the policy of the ___________________________ to ensure balance, independence, objectivity, and scientific rigor in all its individually sponsored or jointly sponsored educational programs. All faculty participating in any ___________________________ sponsored programs are expected to disclose to the program audience any real or apparent conflict(s) of interest that may have a direct bearing on the subject matter of the continuing education program. This pertains to relationships with pharmaceutical companies, biomedical device manufacturers, or other corporations whose products or services are related to the subject matter of the presentation topic. The intent of this policy is not to prevent a speaker with a potential conflict of interest from making a presentation. It is merely intended that any potential conflict should be identified openly so that the listeners may form their own judgments about the presentation with the full disclosure of the facts. It remains for the audience to determine whether the speaker's outside interests may reflect a possible bias in either the exposition or the conclusions presented.

PROGRAM: __________________________________________

DATE: ____________________________________________

TITLE OF PRESENTATION: ____________________________________________

PRESENTERS

NAME: ____________________________________________

(Please print or type)

I have no actual or potential conflict of interest in relation to this program or presentation.

__________________________________________________________________________

Signature Date

I have a financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of this presentation.

<table>
<thead>
<tr>
<th>Affiliation/Financial Interest</th>
<th>Name of Organization(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grant/Research Support</td>
<td>______________________</td>
</tr>
<tr>
<td>Consultant</td>
<td>______________________</td>
</tr>
<tr>
<td>Speakers' Bureau</td>
<td>______________________</td>
</tr>
<tr>
<td>Major Stock Shareholder</td>
<td>______________________</td>
</tr>
<tr>
<td>Other Financial or Material Support</td>
<td>______________________</td>
</tr>
</tbody>
</table>

__________________________________________________________________________

Signature Date

Your cooperation in complying with this standard is appreciated. Please return this form as soon as possible to the program director or Office of Continuing Education.
Appendix E: Random On-site Visit Guidelines

1. Trigger Event
   a. AOA’s Council on Osteopathic Continuing Medical Education (COCME) reserves the right to inspect any provider of CME for just cause.
   b. Violations must be received in writing and of sufficient severity and/or repeated violation to endanger provider’s accreditation.
   c. Rule must be clear and not open to interpretation.
   d. Violation is willful and not based on ignorance of rules and requirements.
   e. Complaints would require onsite verification of offense and are not paperwork in nature.
   f. Nature of violation would be under control of the provider.
   g. Provider has not made attempt to correct violation after notice.
   h. Written complaints to COCME will result in provider being asked to provide any complaints received directly by provider and report of outcome.
   i. An onsite visit is a last resort to assist a Sponsor with keeping their accreditation.

2. Procedure for Audits
   a. Written notification would be sent to provider for response. Failure to respond would be reason enough to trigger onsite inspection.
   b. Event audited would have to be of like nature as event which received complaints.
   c. A minimum number of auditors will be sent – regardless of hardship.
   d. Strict adherence to Crosswalk will be required.
   e. Onsite audit must be approved by COCME.

3. Define Formal Complaint
   a. A formal complaint may be lodged with the COCME by any physician, student, staff, or outside individual. Complaint must be in writing and must be signed.
   b. Anonymous complaints will not be deemed sufficient to require onsite inspection.

4. Define Financial Hardship
   a. It is up to the provider to declare and demonstrate financial hardship. Financial hardship is the inability to pay for travel expenses incurred during the audit.
   b. It is assumed that hardship would generally be an issue for a small state society rather than a hospital or COM.
   c. Suggested requirement would include a letter from President/CEO, appropriate financial reports, current profit and loss statements for 6 and 12 months.
   d. Standards indicate requirements for expenses including air travel, accommodations, per diem and honoraria for inspector.

Purpose of process is to protect accreditation status of the group and to maintain highest CME standards. Remediation and correction is desired outcome. Failure to correct may result in removal of accreditation, probationary status or additional training/oversight of meetings. Appeal process would apply.
GLOSSARY

Terms used in this Manual are related to the Federal Food, Drug, and Cosmetic Act, the American Osteopathic Association Accreditation Requirements for American Osteopathic Association Category 1 CME Sponsors, and the AOA Uniform Guidelines, and the Accreditation Requirements for AOA Category 1 CME Sponsors.

This list of terms has been compiled to furnish users of the document, American Osteopathic Association Accreditation Requirements for AOA Category 1 CME Sponsors, with a common terminology. The availability of the glossary, it is hoped, will lead to a clear understanding of the intent of these Requirements and Guidelines.

Accreditation: The standard, five-year term awarded to accredit CME Sponsors that meet the appropriate AOA CME requirements. Accreditation is awarded by the AOA Council on Osteopathic Continuing Medical Education (COCME).

Accreditation with Commendation: The highest accreditation status, accompanied by a five-year term of accreditation. Accreditation with Commendation is available only to CME Sponsors seeking reaccreditation, not to initial applicants. CME Sponsors must demonstrate compliance with all Accreditation Requirements to achieve Accreditation with Commendation ON THE FIRST ATTEMPT.

Accreditation Council for Continuing Medical Education (ACCME): A nonprofit corporation based in Chicago, responsible for accrediting US institutions that offer continuing medical education (CME) to physicians and other health care professionals. The ACCME also has a system for recognizing state medical societies as accreditors for local organizations offering CME. The ACCME’s mission is to identify, develop, and promote rigorous national standards for quality CME that improves physician performance and medical care for patients and their communities. ACCME accreditation is a voluntary, self-regulatory system.

ACCREDITATION CYCLE: THE LENGTH OF ACCREDITATION AWARDED A CME SPONSOR BY THE COCME BASED ON THE SCORING SYSTEM AS DEFINED ON PAGE 15 AND CAN RANGE FROM ONE TO FIVE YEARS.

Accreditation statement: The standard statement that must appear on all CME activity materials and brochures distributed by CME Sponsors.

Accredited Sponsor: See CME Sponsor—Page 34.

Accrediting Organizations: The FDA, in exercise of its administrative discretion, will seek to rely to the extent possible on major accrediting organizations to monitor company-supported educational activities conducted by their accredited providers and ensure that such activities are independent and non-promotional.


Activity: A CME activity is an educational offering that is planned, implemented, and evaluated in accordance with the AOA Accreditation Requirements and accreditation policies.
Additional Locations: A location that is geographically apart from the main campus at which the institution offers at least 50 percent of an educational program. An additional location is geographically apart from the main campus, and offers at least 50 percent of an educational program. The additional location will not have separate administration, faculty, or budgetary independence, all of which are required for a branch campus or for a new COM. Students may be admitted directly to the additional location as their primary place of enrollment. Students from the entire program can take classes at the additional location. THE ADDITIONAL LOCATION MUST HAVE A COMMON CHIEF ACADEMIC OFFICER, FACULTY, BUDGET, AND CURRICULUM WITH THE PARENT COM. STUDENTS MAY BE ADMITTED DIRECTLY TO THE ADDITIONAL LOCATION AS THEIR PRIMARY PLACE OF ENROLLMENT (34 CFR §602.22).

Advertisement: Being generally applied to the universe of industry promotional activities designed to provide information on regulated products, but do not fall within the definition of labeling. The promotion of an off-label use, whether or not in a form deemed to be an advertisement, may give rise to a violation of the labeling provisions of the Act.

Agency: Food and Drug Administration (FDA).

Agency Policy: Covers not only human drugs, which were the subject of the concept paper, but also covers devices, biologics, and veterinary medicines, which are all subject to regulation with regard to labeling and advertising.

Associate Member: The AOA Board of Trustees may grant associate membership to the following individuals: teaching, research, administrative professional staff and employees of osteopathic physician members, colleges and healthcare facilities; or administrative personnel of the AOA or its affiliated organizations.

Attestation Form: An affidavit completed by attendees of a CME program verifying the number of credits earned for participation in the CME activity. This form may be completed electronically, so long as the accredited sponsor has evidence that the participant attended the educational program.

Branch Campus: COMs that have their institutional accreditation status from the COCA. A branch campus is any location of an institution other than the main campus which is permanent in nature, offers courses in educational programs leading to the doctor of osteopathy or doctor of osteopathic medicine degree, has its own faculty and administrative or supervisory organization, has its own budgetary and hiring authority, and may have affiliated clinical sites. These will be considered a Branch Campus and must follow the procedures outlined under Chapter VI: USDE Requirements COCA MAY SERVE AS THE PROGRAMATIC OR INSTITUTIONAL ACCREDITOR FOR COMS WISHING TO REQUEST A BRANCH CAMPUS. (34 CFR §602.2)

Clinical Assessment Program (CAP): CAP is a Web-based performance measurement program which analyzes data taken directly from patient medical records.

Clinical COM Faculty: A clinical faculty member is an osteopathic or allopathic physician who has undergone a formal committee review of his/her credentials, who has been given a faculty appointment by the COM, such as Assistant, Associate, or full Professor of the relevant department. This appointment is based on merits of various academic criteria, not just a review of
the applicant's CV, and it may be paid or unpaid. This is different than a preceptor, who may have been appointed based on a brief review of credentials.

Clinical Didactic Teaching: A CME activity based on the physician learner's preparation to teach in a live CME activity (classroom style).

CME Sponsor: A CME Sponsor is an institution, organization or affiliate that is accredited by the AOA Council on Osteopathic CME to present programs that qualify for AOA Category 1 CME credit.

CME Sponsors have the discretion of allowing other non-AOA accredited organizations, termed “Providers”, to conduct CME programs under their accreditation status. It is the CME Sponsor's responsibility to ensure that the Provider's programs follow the AOA Category 1 CME Requirements.

CME Provider: A CME Provider is an organization, which is not, itself, a recognized AOA Category 1 CME Sponsor, but is authorized to offer AOA approved Category 1 CME under the direction and approval of a recognized AOA Category 1 CME Sponsor.

Commercial Bias: Content or format in a CME activity or its related materials that promotes the products or business lines of an AOA-defined commercial interest.

Commercial Interest: A commercial interest, as defined by the AOA, is any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients. The AOA does not consider sponsors of clinical service directly to patients to be commercial interests. A commercial interest is not eligible for AOA accreditation.

Commercial support: Monetary or in-kind contributions given to a CME sponsor that is used to pay for all or part of the costs of a CME activity.

Compliance: The finding given when a CME sponsor has fulfilled the AOA’s requirements for the specific criterion in the Accreditation Criteria or policy.

Conflict of interest: The AOA considers financial relationships to create conflicts of interest in CME when individuals have both a financial relationship with a commercial interest and the opportunity to affect the content of CME about the products or services of that commercial interest. The potential for maintaining or increasing the value of the financial relationship with the commercial interest creates an incentive to influence the content of the CME – an incentive to insert commercial bias. See also relevant financial relationships.

Continuing Medical Education (CME): Continuing medical education consists of educational activities that serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is the body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public.
Core Competencies:

1. Osteopathic Philosophy/Osteopathic Manipulative Medicine – Demonstrate and apply knowledge of accepted standards in osteopathic manipulative treatment appropriate to the specialty. Remain dedicated to life-long learning and to practice habits in osteopathic philosophy and OMM.

2. Medical Knowledge – Demonstrate and apply knowledge of accepted standards of clinical medicine in the respective area; remain current with new development in medicine and participate in life-long activities.

3. Patient Care – Demonstrate the ability to effectively treat patients and provide medical care that incorporates the osteopathic philosophy, patient empathy, awareness of behavioral issues, the incorporation of preventive medicine and health promotion.

4. Interpersonal and Communication Skills – Demonstrate interpersonal and communication skills that enable you to establish and maintain professional relationships with patients, families, and other members of health care teams.

5. Professionalism – Uphold the Osteopathic Oath in the conduct of one’s professional activities that promotes advocacy of patient welfare, adherence to ethical principles, and collaboration with health professionals, lifelong learning, and sensitivity to a diverse patient population; be cognizant of physical and mental health in order to effectively care for patients.

6. Practice-Based Learning and Improvement – Demonstrate the ability to critically evaluate methods of clinical practice, integrate evidence based medicine into patient care; who and understanding of research methods; improve patient care practices.

7. Systems-Based Practice – Demonstrate an understanding of health care delivery systems; provide effective and qualitative patient care with the system; and practice cost effective medicine.

Co-sponsored activity: A CME activity presented by two or more accredited sponsors. One of the accredited sponsors must take responsibility for the activity in terms of meeting AOA requirements and reporting activity data to the AOA. See also directly sponsored activity.

Course: A live CME activity where the learner participates in person and which is planned on a one-by-one basis and designated for credit as a single activity. (Examples: annual meeting, conference, seminar.)

Credit: The “currency” assigned to CME activities. Physicians and other health care professionals use credits to meet requirements for maintenance of licensure, maintenance of specialty board certification, credentialing, membership in professional societies, and other professional privileges. The requirements for credit designation are determined by the organization responsible for the credit system.

Enduring Materials: CME activities that are printed, recorded, or accessible online and do not have a specific time or location designated for participation. Rather, the participant determines where and when to complete the activity. Examples: online interactive educational module, recorded presentation, podcast.

Faculty: The professionals responsible for teaching, authoring, or otherwise communicating the activity content.
Faculty Development programs: Faculty Development refers to those programs which focus on the individual faculty member. The most common focus for programs of this type is the faculty member as a teacher. Faculty development specialists provide consultation on teaching, including class organization, evaluation of students, in-class presentation skills, questioning and all aspects of design and presentation. They also advise faculty on other aspects of teacher/student interaction, such as advising, tutoring, discipline policies and administration.

A second frequent focus of such programs is the faculty member as a scholar and professional. These programs offer assistance in career planning, professional development in scholarly skills such as grant writing, publishing, committee work, administrative work, supervisory skills, and a wide range of other activities expected of faculty.

A third area on which faculty development programs focuses is the faculty member as a person. This includes wellness management, interpersonal skills, stress and time management, assertiveness development and a host of other programs which address the individual’s well-being.

Not all faculty development programs include all these areas, most of them have as their philosophy the faculty member as the driving force behind the institution; therefore, assisting that person to be as productive as possible will make the entire institution more productive.

Financial Relationships: Financial relationships are those relationships in which the individual benefits by receiving a salary, royalty, intellectual property rights, consulting fee, honoraria, ownership interest (e.g., stocks, stock options or other ownership interest, excluding diversified mutual funds), or other financial benefit. Financial benefits are usually associated with roles such as employment, management position, independent contractor (including contracted research), consulting, speaking and teaching, membership on advisory committees or review panels, board membership, and other activities from which remuneration is received, or expected. The AOA considers relationships of the person involved in the CME activity to include financial relationships of a spouse or partner.

GAP ANALYSIS: (SEE PRACTICE GAP ANALYSIS).

Grand Rounds Programs: Grand rounds are an important teaching tool and ritual of medical education and inpatient care, consisting of presenting the medical problems and treatment of a particular patient to an audience consisting of doctors, residents and medical students. Grand rounds help doctors and other healthcare professionals keep up to date in important evolving areas which may be outside of their core practice. Most departments at major teaching hospitals will have their own specialized, often weekly, Grand Rounds. Grand rounds tend to present the bigger picture, including experience with patients over many years, and the newest research and treatments in an area.

INTERNET ENDURING MATERIAL ACTIVITY: AN ENDURING MATERIAL PROVIDED VIA THE INTERNET, MEANING THAT THERE IS NO SPECIFIC TIME DESIGNATED FOR PARTICIPATION. RATHER, THE PARTICIPANT DETERMINES WHEN TO COMPLETE THE ACTIVITY. EXAMPLES: ONLINE INTERACTIVE EDUCATIONAL MODULE, RECORDED PRESENTATION, PODCAST.

Internet live activity: An online course available at a certain time on a certain date and is only available in real-time, just as if it were a course held in an auditorium (I.E., WEBCAST.

Internet On-Demand Activity: A pre-recorded online course that can be viewed at any time.
Joint sponsorship: Sponsorship of a CME activity by one accredited and one non-accredited organization. The accredited sponsor must take responsibility for a CME activity when it is presented in cooperation with a non-accredited organization and must use the appropriate accreditation statement.

Journal-based CME activity: An activity that includes three phases: the participant reads an article in print or in a format adapted for special needs, engages in a self-directed phase stipulated by the accredited sponsor that may include reflection, discussion, or debate about the article, and completes a pre-determined set of questions or tasks related to the article content.

Labeling: Include not only product labels but also other written, printed, or graphic matter that "accompanies" a product.

Maintenance of Certification (MOC): The process by which ABMS board certified physicians maintain their time-dated certifications. MOC requires four components: Licensure and Professional Standing; Lifelong Learning and Self-Assessment; Cognitive Expertise; and Practice Performance Assessment.

Marketing: Marketing is the activity, set of institutions, and processes for creating, communicating, delivering, and exchanging offerings that have value for customers, clients, partners, and society at large.

Needs Assessment: A needs assessment is an analysis of the type of CME that is needed by the intended audience for a CME program, which has been proposed or conducted. The results of a needs assessment are used in the design and planning of the content and delivery modality for CME programs. There are four criteria that must be met when requesting AOA Category 1-A or Category 1-B credit for approval. See Section II, Part D, for the criteria for needs assessment (Pages 6-7).

Noncompliance: The finding given when a CME Sponsor does not fulfill the AOA’s requirements for the specific criterion in the Accreditation Requirements or policy.

Objectives: Statements that clearly describe what the learner will know or be able to do after participating in the CME activity. The statements should result from the needs assessment data. Providers may also state the purpose of an individual activity in lieu of developing specific objectives.

Online CME: Continuing medical education obtained from various sources on the Internet.

Osteopathic Continuous Certification (OCC): The process by which AOA board certified physicians maintain their time-dated certifications. OCC requires five components: Unrestricted Licensure; Lifelong Learning/Continuing Medical Education; Cognitive Assessment; Practice Performance Assessment and Improvement; and AOA Membership.

Osteopathic Faculty: The following shall be considered osteopathic faculty: 1) Osteopathic Physicians, 2) MDs, PhDs, and other professionals with graduate degrees who hold a full-time paid faculty appointment at a college of osteopathic medicine, 3) Presenting employees of the American
Osteopathic Association or AOA component society staff who hold a graduate degree and clinical faculty.

Osteopathic Graduate Medical Educator (OGME): Full-time clinical faculty of OGME Programs.

Osteopathic Recognition: An extra designation secured by ACGME-accredited programs that offer training in osteopathic manipulative medicine and the osteopathic philosophy.

Outcome Measurement: The tabulation, calculation or recording of activity or effort that can be expressed in a quantitative or qualitative manner (when attempting to measure shifts or progress toward desired levels of quality).

Osteopathic Principles and Practice (OPP): The fundamental approach to patient health and wellness guided by the tenants of osteopathic medicine.

Participant: An attendee at a CME activity.

Performance Improvement CME: An activity based on a learner’s participation in a project established and/or guided by a CME provider. A physician identifies an educational need through a measure of his/her performance in practice, engages in educational experiences to meet the need, integrates the education into patient care, and then re-evaluates his/her performance.

Physician: A physician is a healthcare provider who is licensed to practice medicine and surgery in all its branches. In the United States, osteopathic physicians DOs and allopathic physicians MDs are the two recognized types of physicians under this definition. This type of physician is also described as having full practice privileges, and is sometimes referred to as a “complete” physician. Each state will have laws which define the practice privileges of various healthcare providers and which may permit these providers to use the physician descriptor when referring to their practices.

Planning Process: The method(s) used to identify needs and assure that the designed educational intervention meets the need(s) and produces the desired result.

Presenter: A presenter at an AOA-accredited CME program is an individual who chairs a portion of the program or who delivers a lecture or other formal portion of the program.

PRACTICE GAP ANALYSIS (NEEDS ASSESSMENT): A PRACTICE GAP ANALYSIS IS AN ANALYSIS OF THE TYPE OF CME THAT IS NEEDED BY THE INTENDED AUDIENCE FOR A CME PROGRAM, WHICH HAS BEEN PROPOSED OR CONDUCTED. THE RESULTS OF PRACTICE GAP ASSESSMENTS ARE USED IN THE DESIGN AND PLANNING OF THE CONTENT AND DELIVERY MODALITY FOR CME PROGRAMS. THERE ARE FOUR CRITERIA THAT MUST BE MET WHEN REQUESTING AOA CATEGORY 1-A OR CATEGORY 1-B CREDIT FOR APPROVAL.

Probation: Accreditation status given to accredited sponsors that have serious problems meeting AOA requirements. Probation may also be given to providers whose document surveys are rejected. The accredited sponsor is allotted 10 working days to correct the noncompliance issues in order to achieve accreditation status before submitted to the AOA Council on Osteopathic CME. While on probation, a sponsor/provider may not sponsor/jointly sponsor new activities.
Program: A formal educational program presented.

Program Sponsor: A program sponsor is an organization that is recognized by non-AOA accreditor and/or offers CME programs recognized by non-AOA organizations. An example of one such accrediting agency is the Accreditation Council for Continuing Medical Education (ACCME) that accredits CME sponsors, but does not approve individual programs. The American Academy of Family Physicians (AAFP) approves individual programs, but does not accredit sponsors.

Provider: A non-AOA accredited organization that provides CME programs under the discretion and approval of an AOA Accredited Category 1 CME Sponsor.

Reduction: The act of decreasing a physician’s CME requirement based on individual mitigating circumstances.

Regularly Scheduled Conferences (RSC’s): A course is identified as an RSC when it is planned to have 1) a series with multiple sessions that 2) occur on an ongoing basis (offered weekly, monthly, or quarterly) and 3) are primarily planned by and presented to the accredited organization’s professional staff.

Regulated Industry: Persons or entities that manufacture, sell, or conduct research on human and animal drugs, biological products, and medical devices.

Safe Harbor: Scientific and educational activities that are supported by the regulated industry but are independent of promotional influences that may emanate from the supporting companies. Within the perimeters of the safe harbor, activities may be funded by the regulated industry, may be designed to provide information on the use of regulated products, and yet be left free from regulation under the labeling and advertising provisions of the Federal Food, Drug, and Cosmetic Act.

Safe harbor is based not on a distinction between promotion and education, but rather on a distinction between activities that are subject to influence by the regulated industry and independent activities that are free from promotional influences. Educational value does not provide a safe harbor from agency regulation; educational activities that are designed or influenced by the regulated industry, even if of the highest educational quality, are subject to regulation.

The general characteristics of the traditional safe harbor for industry-supported scientific and educational activities are (1) an understanding between the provider and supporting company that the activity is to be a scientific or educational activity, and not designed to promote the supporting company’s product, (2) functional independence on the part of the provider from influence over content by the supporting company, and (3) adequate disclosure of supporting company involvement.

Sponsors Overall Program: The range and scope of CME (clinical educational) activities which are offered by an AOA accredited CME Sponsor.
Staff Physician: A staff physician is a physician who has been given practice privileges at a healthcare facility. Such privileges are granted after review of credentials that include: an unrestricted license to practice medicine; completion of postdoctoral education; attainment of certification.

Standards to Ensure Independence in CME Activities: AOA requirements designed to ensure that CME activities are independent and free of commercial bias.

Supporter: See commercial interest and commercial support.


Test-item writing: A CME activity based on a learner’s participation in the pre-publication development and review of any type of test item. Examples: multiple choice questions, standardized patient cases.

Uniform Guidelines: Uniform Guidelines for Accrediting Agencies of Continuing Medical Education as adopted by the AOA (Page 4).

Waiver: The act of modifying a physician’s CME requirement due to mitigating circumstances. Waivers granted do not affect the CME requirement for state licensing boards, specialty colleges, or other organizations.

Written Agreement: Companies and providers who wish to ensure that their activities will not be subject to regulation should design and carry out their activities based on written agreement between the company and the provider documenting that the provider will be solely responsible for designing and conducting the activity, and that the program will be educational and non-promotional in nature.

The written agreement shall provide for appropriate disclosure. If the company abides by such an agreement and does not otherwise circumvent the purpose of the agreement, the FDA does not intend to regulate the activity under the labeling and advertising provisions of the Federal Food, Drug, and Cosmetic Act.
WHEREAS, the current policy is to award AOA Category 1-B credit for exam construction item writing; and

WHEREAS, the COCME strongly believes that item writers should be awarded AOA Category 1-A CME credit; now, therefore be it

RESOLVED, that item writing be approved for AOA Category 1-A credit with a cap of 20% of the required CME per 3 year AOA CME cycle; and, be it further

RESOLVED, that physicians earn 1 credit for developing 6 exam questions accepted by an AOA certifying board or conjoint committee, and/or the National Board of Osteopathic Medical Examiners.

Explanatory Statement:
The COCME recommends AOA Category 1-A CME credit for item writing for licensure purposes. The resolution will be forwarded to the AOA Bureau of Osteopathic Specialists to see if they wish to have exam writing be considered Category 1-A or 1-B for the purpose of board certification CME.

FISCAL IMPACT: 0

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED that the following Revisions to Basic Standards for Residency Training in Surgery and the Surgical Subspecialties be APPROVED.

(old material crossed out; new material in capital letters)

SECTION IV: INSTITUTIONAL REQUIREMENTS

B. Resources

Resources must include:

4.3 Resources must include:

... e. There must be a full-time program coordinator designated specifically for resident education support and programs with more than 20 residents must also have an assistant or associate program coordinator. (See Appendix II, B.2.1 for further clarification.)

f. Each resident must SHOULD attend the Annual Clinical Assembly of Osteopathic Surgeons (ACA) at least once during their residency training program;

... 4.5 Each resident must be registered to utilize the ACOS approved electronic data collection/log system.

... D. Discipline Specific Requirements

General Surgery

... 4.9 There must be a minimum of five funded positions

Cardiothoracic

4.10 The primary training institution must provide funding for at least one (1) EACH cardiothoracic trainee per training year.

... Neurological Surgery

4.13 The institution must provide institutional resources to train at least one EACH resident per year of training.

Plastic and Reconstructive Surgery

4.14 The primary training institution and affiliated sites must provide funding for at least two (2) EACH plastic surgery resident positions.
SECTION VI: PROGRAM PersonNEL AND RESOURCES

Program Director

Duties of the program director must include:

... 6.11 ENCOURAGED TO Attend the ACOS Osteopathic Surgical Educators' Seminar at least once every two years;

... 6.12 Not accept/appoint more residents than approved by the AOA, and

Specialty Specific Requirements of the Program and Program Director

General Surgery

6.16 The program director's initial appointment will be for 72 months for the continuity of the program.

6.17 Qualifications of the general surgery program director and the faculty:

... c. At least one of the faculty must be AOA board certified or board eligible in general surgery

Urological Surgery

6.30 The program director's initial appointment will be for no less than 72 months for continuity of the program.

SECTION VII: RESIDENT APPOINTMENT REQUIREMENTS

7.7 Each resident must attend at least one ACOS annual clinical assembly during their residency training.

APPENDIX TWO: Policy and Procedures

A. APPLICATIONS FOR NEW RESIDENCY PROGRAMS

Completed applications for new osteopathic residency training programs are delivered to the AOA division of postdoctoral training with the following required information:

- Current Segregated Totals.
- Curriculum Vitae of Program Director.
- Written Program Description.
- A list of faculty, with certification status of each faculty member, where appropriate.
- Current affiliation agreements for all outside rotations.
- The Curriculum Vitae of the Director of Osteopathic Medical Education.

The AOA forwards the completed application to the ACOS. Upon receipt of a new program application, ACOS staff will provide notification to the program of the expectation of when the application might be considered by the RESC and forwarded to the AOA PTRC for action.

If timely, the RESC or an RESC Administrative committee will review the application and indicate whether a site visit of the proposed program should be scheduled prior to consideration of the new program application by the RESC. At this point any questions or clarification of materials will be
requested from the program. All new program applications require a pre-inspection site visit by an
AOA-approved site visitor prior to final approval by the RESC.

Following RESC review of the application and/or pre-inspection site visit report, one of the following
recommendations will be submitted to the AOA PTRC for final action in accordance with AOA policy:

- **APPROVAL** — An osteopathic institution requesting permission to begin a new residency
  training program may only be recommended for approval with reinspection within one year of the
  commencement date of residents in training. This recommendation is only used for new program
  requests found to have no major deficiencies in the written program, adequate faculty, and adequate
  scope, volume and variety to support a training program with a minimum of three resident slots.
  (Fellowships are exempted from this requirement.)

- **DENIAL** — Denial of approval indicates that the request for a new program has been reviewed
  and major deficiencies or violations of AOA Standards have been identified in either the pre-inspection
  site visit, or in the material submitted by the institution. Recommendations of denial of approval must
  be stated clearly and cross-referenced with the basic training standards of the specialty and/or the
  residency standards of the AOA.

- **DEFERRAL** — Deferral of action may be taken on the request for new training programs if the
  reviewer(s) finds that the proposed program requires an on-site evaluation and/or if the file lacks any
  of the following — an acceptable program description; suitable statistical material; proper affiliation
  agreements, and/or the required pre-inspection site visit. The institution will be given 30 days from the
  date of action by the RESC to submit the information needed to make a recommendation. Failure to
  respond to the request for information by the RESC will allow the specialty college to evaluate the
  inspection report at its next scheduled meeting and base a recommendation on the information present
  at the time of review. Specialty colleges do not have the authority to defer programs longer than the
  time allowed for specialty colleges to make their response to the AOA PTRC for action.

C. PROCEDURES FOR RESIDENT INCREASES IN ESTABLISHED PROGRAMS

1. The RESC shall review the application materials for increases and make a recommendation to
   the AOA PTRC. The RESC shall recommend approval or denial. It may also defer pending the
   receipt of additional materials:

   a. Applications for increases in established residency programs that do not comply with
      AOA/ACOS Standards, shall be recommended for denial. Recommendations for denial
      shall be accompanied by a description of areas of non-compliance which are cross-
      referenced to the basic standard documents for that specialty.

   b. Applications for increases in established residency programs that do not contain correct
      information or are deemed incomplete, shall have action deferred for a period of thirty days
      to allow the program to correct the application. Failure to do so will result in a
      recommendation for denial at the next meeting.

2. The PTRC shall take final action on all applications for increases in established residency
   programs. Such action shall be based on the recommendation of the ACOS/RESC.

D. Advanced standing: Residents may petition the ACOS for advanced standing based on training in
previous years, to include, but not limited to, training in another specialty training program, military
training, or a traditional rotating internship, differing from required surgical first year for that
specific residency program. Such requests are granted only for 12-month periods, and are approved
by the ACOS/RESC and reported to the AOA and the OPTI. Furthermore, residents who were
required to repeat a training year cannot utilize the repeated year towards the fulfillment of their
primary or secondary programs. The training program and resident position must be AOA-approved or ACGME-accredited prior to commencement of the resident’s training. No more than one month advanced standing will be awarded for one month of alternative training.

Documentation, which must be submitted for consideration of advanced standing, must include the following:

1. Evaluations and verification by the director of the previous program that the training was successfully completed;
2. A resident report, on the appropriate report form, documenting procedures performed;
3. A written description of the program, and a schedule of rotations completed; and
4. A scientific paper that is either an original contribution or a case report. Original contributions will document original clinical or applied research. Case reports will document unusual clinical presentations with newly recognized or rarely reported features. The length of the paper shall be at least 1500 words, double spaced, paginated, with references required for all material derived from the work of others; or (for training completed after July 2007) documentation of a scholarly activity as a result of the resident’s progressive acquisition of critical appraisal and personal research skills. The scholarly project for the training year must be evaluated by the program director using the program director’s annual resident evaluation report for surgery.
5. A written letter evaluating the level of training of the resident by the program director accepting the resident into the new program, if applicable. (It is the prerogative of the program director to develop a teaching/remediation plan for the resident, not to exceed one year.

G. Research Sabbatical: General surgery residents may participate in 12 months of research at the approval of the program director. The sabbatical year may be taken following an OGME-2 or OGME-3 general surgery training year. The research training year may not count towards the minimum number of years that must be AOA-approved for program completion nor may it conflict with the continuity of training policy that requires the last two years at the same training institution.

APPENDIX THREE: OGME-1R (First Year Residency) Requirements —
General Surgery, Neurological Surgery and
Urological Surgery

The first year of the residency program (OGME-1R) for general surgery, urological surgery, and neurological surgery must include the following rotations. These rotations may be scheduled as 12 one-month rotations or 13 four-week rotations or any combination thereof:

1. Rotations for ½ day per week, for 46 weeks, in an out-patient clinic or office.
2. Two months of general internal medicine
3. One month of ICU
4. One month of emergency medicine
7. Four months of general surgery
8. Four months of selectives to include any of the following areas:
   a. Urology
   b. Orthopedics
   c. Anesthesia
   d. ENT
e. General Surgery
f. Vascular Surgery
g. Neurosurgery
h. Cardiovascular Thoracic Surgery
i. Plastic and Reconstructive Surgery
j. Radiology
k. One month of female reproductive medicine
l. One month of pediatrics, if available, or other primary care specialty, at the discretion of the training institutions.

These requirements may be altered at the discretion of the Program Director, with the approval of the sponsoring institution’s GME committee, Director of Medical Education, and the Residency Education Standards Committee (RESC), which will best serve the experience of the resident. Programs not complying with these OGME-1R requirements must provide their actual rotation schedule to the RESC and a rationale for any variance.

The OGME-1R year of fundamental skills must be organized so that residents participate in clinical and didactic activities to:

- develop the knowledge, attitudes and skills needed to formulate principles and assess, plan, and initiate treatment of patients with surgical and medical problems;
- be involved in the care of patients with surgical and medical emergencies, multiple organ system trauma, and nervous system injuries and diseases;
- gain experience in the care of critically ill surgical and medical patients;
- participate in the pre-, intra-, and post-operative care of surgical patients; and
- develop basic surgical skills and an understanding of surgical anesthesia, including anesthetic risks and the management of intra-operative anesthetic complications.

OGME-1R residents will log case exposure during the first training year in the approved case log system. These procedures will be counted toward the total procedures required by completion of the program.

FISCAL IMPACT: 0

ACTION TAKEN ________________________

DATE ______________________________
SUBJECT:  REVISIONS TO OPTI ACCREDITATION HANDBOOK


REFERRED TO: AOA Board of Trustees

WHEREAS, the Council on Postdoctoral Training requested the Council on Osteopathic Postdoctoral Training Institutions revise its standards and eliminate requirements not focused upon meeting immediate needs and those unlikely to change the outcome of resident training for programs under the AOA's restricted accreditation after 6/30/20; and

WHEREAS, a survey was developed to get feedback from OPTI leaders on each OPTI standard and whether the standard should remain, be eliminated, be revised; and

WHEREAS, COPTI reviewed the results of the survey and the OPTI accreditation handbook; now, therefore be it

RESOLVED, that the following Revisions to the OPTI Accreditation Handbook be APPROVED.

(old material crossed out; new material in capital letters)

Part One: COPTI Policies and Procedures

B. Responsibilities and Functions

3. The COPTI has the responsibility for interpreting the standards of accreditation, but has no authority to waive compliance with any standards by any OPTI.

5. The COPTI shall serve as the advisory body on OPTI policy to the COPT-PTRC AND BOE.

6. Review on-site evaluation reports as part of the evaluation of applications for new OPTIs, or evaluations for continuing recognition of accredited OPTIs.

7. The COPTI shall conduct periodic review of OPTI standards on three-year basis, starting January 2010.

…

G. Procedures for COPTI Meetings

2. OPTI Accreditation and Effectiveness Activities

a. The COPTI must review applications for new OPTIs, on-site evaluation/accreditation reports and other supporting documentation and make final accreditation action during Executive Session.

…

e. The COPTI must conduct training workshops for on-site reviewers every other year.

d. The COPTI must conduct annual workshops for the benefit of the entire OPTI community on topics that are identified by needs analysis.

e. The COPTI must make recommendations on policy issues pertaining to OPTIs and transmit them to the COPT BOE for their review.
Part Two: OPTI Administrative Policies and Procedures

A. OPTI Responsibilities

1. OPTIs must pay an annual accreditation fee set by the AOA. Failure of payment may result in withdrawal of accreditation.
   a. If a new OPTI is formed in the calendar year, the OPTI must pay the annual accreditation fee.

2. a. When a change in an OPTI membership occurs, the new partner OPTI must send a copy of the affiliation agreement NOTIFICATION to the AOA Department of Education within 30 working days.

B. New OPTI Application Process

1. Proposed new OPTI shall submit a signed application form (See Appendix A) by the administrative officer of the proposed OPTI to the AOA Division of Postdoctoral Training.
2. The non-refundable fee for examining credentials submitted in application for accreditation status is $500 U.S. dollars.
3. A self-study must be prepared and submitted as part of the application and address the following:
   a. Sections A and B of the OPTI standards with proposed mechanisms to address all remaining OPTI standards
   b. Demonstrate the clear commitment of each member institution to the OPTI’s mission, operation, development, and financial support
   c. The self-study report must demonstrate that the new OPTI has obtained appropriate support for approval to grant postdoctoral certificates to DOs.
   d. A statement attested to by all governing boards of the members of the proposed OPTI demonstrating a commitment to a shared mission and an organization chart, which illustrates the structure and administration.
4. A statement of the OPTI’s governance, which includes a copy of bylaws or equivalent documents.
5. A three-year projection of financial resources available to support the OPTI’s operations.
6. Demonstrate and document the availability of inpatient and ambulatory clinical training sites, including patient volumes, scope and variety for the internship program(s) and the applied for residency program.

C. Evaluation of Application

1. After receipt of a completed application and review by AOA staff, the COPTI must evaluate the application at its next regular meeting and either request further information or authorize staff to schedule a site visit.
2. All costs of the AOA site visit shall be the responsibility of the OPTI.
3. After reviewing the site visit report and other pertinent materials, the COPTI must take action and recommend a term of provisional approval until the next site visit is required, or recommend denial of provisional accreditation.

D. Definition of Accreditation Status

1. Applicant Status
   a. Applicant status is the initial step in seeking accreditation. This is offered without rights or privileges of accreditation, and does not establish or imply recognition by the AOA.
   b. Applicant status is granted upon formal request for evaluation submitted to the COPTI by the official representative of the applicant OPTI.
2. Provisional Accreditation
   a. To be considered for provisional accreditation, proposed new OPTIs must demonstrate evidence of the capacity to comply with the requirements for accreditation.
   b. Provisional Accreditation is conferred for one year to a new OPTI that, at the time of the site visit demonstrates its preparedness to initiate requirements for an OPTI in accordance with the Basic Standards. Provisional Accreditation starts as dated by the approval letter from the COPTI.
   c. COPTI may approve a one year renewable extension if there is reasonable rationale for the decision. A Provisional Accreditation status cannot exceed a total of two years.
   d. A Provisional Accreditation visit is conducted after all requirements for applicant status have been met. The accreditation application, the site visit report, and the evaluation by the COPTI must determine whether to award Provisional Accreditation. Provisional Accreditation does not ensure any subsequent accreditation status.

3. Full Accreditation
   a. Accreditation status confers all rights and privileges of accreditation
   b. Accreditation status is reviewed within a maximum five year survey cycle or sooner if warranted. Once accreditation status is attained, the OPTI shall retain that status until the COPTI may withdraw it.
   c. Accreditation actions and renewal of accreditation are based upon an on-site evaluation.

E. OPTI Annual Report
   2. The annual report shall be submitted to the AOA no later than the published October deadline. If annual reports are not received by the published October deadline, COPTI may review the accreditation status of the OPTI for reconsideration or request a focused site visit.

G. OPTI Feasibility Study
   1. An applicant OPTI must file a letter of intent. An introductory packet of information will be mailed to assist the organization in filing necessary documentation.
   2. An OPTI applying for provisional accreditation status must submit a feasibility study with the application. The feasibility study must address the following:
      a. Section 1 – Overview and History of the OPTI Formation Concept and Process
      b. Section 2 – Self-Study Organized by the Following OPTI Standards:
         i. Section A: Prerequisites for Accreditation (all standards)
         ii. Section B: Organization and Governance.

H. OPTI On-Site Evaluations
   1. There are three types of on-site evaluations: full surveys, AND focused visits, and provisional accreditation visits.
   2. COPTI HAS THE AUTHORITY TO EXTEND THE ACCREDITATION OF AN OPTI WITHOUT CONDUCTING AN ON-SITE EVALUATION.
      4.e If an applicant OPTI refuses to permit the on-site evaluation, the applicant OPTI is automatically denied accreditation status.

I. Full On-Site Evaluation
   2. The AOA Department of Education must notify OPTIs in writing 12 months before a full on-site evaluation.
3. The duration of the OPTI on-site visit must be agreed upon in advance (no later than 45 days) by the CAO, OPTI and AOA team leader allowing sufficient time for completion of the draft report by the on-site team prior to the exit conference.

... 

5. Loss or denial of approval of a residency program at an OPTI does not affect the OPTI's accreditation status unless the action causes the OPTI to be no longer in compliance with the standards (i.e. leaving the OPTI with only one residency program).

... 

K. Provisional Accreditation Site Visits

1. Provisional accreditation site visits must be conducted for OPTIs seeking accreditation.

2. Dates of the visit must only be set after the applicant OPTI has submitted all paperwork to the COPTI.

3. The provisional accreditation site visits ordinarily must require one day and must focus on the particular area(s) identified by the COPTI.

4. OPTI reviews must examine Sections A and B of the OPTI standards only.

5. The COPTI shall designate a chair for each visit. The chair is responsible for the organization of the visit and the preparation of the final report and recommendations.

6. At the conclusion of the site visit, there shall be an exit conference between the team and representatives of the OPTI designated by the official representative or CAO, as appropriate.

The exit conference shall include an oral report by the team. This report must provide the OPTI with an accurate preview of the final report.

7. A copy of the draft report, including the final recommendations, shall be sent to each team member for review, correction, and/or editing, and to the OPTI's official representative, or CAO as appropriate, for review and correction of factual errors only. Additional material may be submitted by the OPTI to document factual errors in the draft report. This must not be confused with the OPTI's formal response to the report.

8. The visiting team's final report shall be forwarded to the OPTI for review and comment.

9. The visiting team's final report shall reflect consideration of the OPTI's comments, as appropriate, and shall be forwarded to the COPTI.

10. The official representative of an OPTI shall receive notification of an on-site evaluation and a copy of the visiting team report as approved by the COPTI. If the OPTI is organized within a university, the above referenced officers of that university shall also receive the materials specified above.

11. The AOA shall be reimbursed by an OPTI for the direct costs of an on-site evaluation prior to the meeting at which the COPTI is scheduled to take action on that survey evaluation.

... 

M. Accreditation Actions

... 

4. Accreditation with Probation

... 

c. “Accreditation with Probation” status is public and notice shall be provided to all interested parties. A COPTI action of “accreditation with probation” shall be reported to the PTRC AND COPT, BOE, and the commission on osteopathic college accreditation for information and record. The AOA and OPTI shall publicly describe the OPTI's status as Accreditation with Probation.

... 

5. Withdrawal of Accreditation
d. COPTI actions of ‘withdrawal of accreditation’ shall be reported to the commission on osteopathic college accreditation with advice that another OPTI membership should be obtained (consistent with COCA Standards requiring each COM to hold an OPTI membership).

Appendix A – Application for a New OPTI
APPLICATION FOR NEW OSTEOPATHIC POSTDOCTORAL TRAINING INSTITUTE (OPTI)

Appendix C – Document List

The following required documents must be available for site reviewers to review:

• Statement of governance and organizational chart
• OPTI/institutional catalog
• Current affiliation agreements
• Budget for current year
• Most recent OPTI financial report
• Minutes of all standing OPTI committees (at least one prior year)
• OPTI-sponsored education schedules
• OPTI-faculty development schedule
• OPTI internal evaluation program
• Curriculum structure and development

APPENDIX E
COPTI ACCREDITATION AWARD SYSTEM FOR OPTI ACCREDITATION SITE VISITS
(Based on AOA Basic Documents and OPTI Standards effective July 2012)

Introduction

OPTI accreditation has evolved over the past three years as a result of revised standards and a scoring ‘rubric’ established in 2008 in a manner that has prompted improved performance of individual OPTIs and an upward trend in the total number of ‘accreditation years’. While this change is admirable and generally acknowledged as ‘progress’, there is significant feedback that further enhancements in the accreditation processes are needed (M. Hamm and Associates, 2011).

The current methodology assigns one ‘point’ for each element within each of eight standards. The cumulative points accrued are additive and the percentage of points ‘scored’ are compared to the total available for an overall ratio. A ‘scoring rubric’ assigns variable ‘accreditation years’ based on ranges of points scored against the total available. As Standards have been removed in the past three years the scoring tool has been modified to accommodate the changed total points available. Using this methodology, a significant number of OPTIs have achieved a full ‘five year accreditation’ and some have been awarded a ‘blue ribbon’ status for commendations above a ‘perfect five year score’.

One significant issue (among several) with the above method has been identified by OPTI executives and chief academic officers over the past months and reported either through OPTI workshops, OPTI forums, or through the Michael Hamm study on OPTI effectiveness completed in early 2011. The issue of ‘chasing’ points rather than focusing on quality improvement has caused several to suggest an alternate method of accreditation award.
Under the AOA uniform standards review work group guidelines adopted by the AOA Board of Trustees, the OPTI Standards and Processes are to be reviewed on a periodic basis. The current revision cycle for the OPTI Standards, the recent authorization of the AOA BOT for OPTIs to sponsor OGME programs, and the insights gained from the Hamm study provides the opportunity to apply a new concept for accreditation awards for OPTIs.

The following accreditation award concept has been widely adopted by other accrediting units, both in the osteopathic profession (commission on osteopathic college accreditation) and in other higher education accrediting entities.

**General Policies (Also See Table Of Explanation Which Follows):**

1) Each OPTI will receive a 5 year accreditation award if it meets at least 70% of all Standards as written and all ‘must meet’ Standards are met.

2) Any OPTI which fails to demonstrate compliance with two ‘must meet’ Standards shall receive a 5 year “accreditation with notice (private)” and a required focused re-inspection in 12 months.

   a. If any ‘must meet’ Standards remain unmet at the focused 12 month visit, the OPTI will receive the designation of ‘accredited with probation (public)’ and have an additional required focused re-inspection in 1 year.

3) Each OPTI must file a Corrective Action Plan within 75 days of notice of accreditation award outlining plans for correction of deficiencies.

4) Each OPTI must file progress reports with COPTI at 180 days (6 months) following notice of accreditation and every 6 months thereafter for a maximum of 24 months until all deficiencies are corrected. Any OPTI not demonstrating full correction of all deficiencies at 24 months post notice of accreditation award must undergo a focused site review to demonstrate why continued accreditation should exist.

5) On the basis of results of such focused site reviews for regular standards remaining unmet, COPTI must declare one of the following:

   a. Continued 5 year accreditation with noted correction of all current deficiencies

   b. Continued 5 year “accreditation with notice (private)” — required focused re-inspection in 12 months.

   c. If, on the basis of required focused re-inspection as required in 5)b., continued deficiencies exist, COPTI must declare:

      i. ‘Accreditation with probation (public)’ followed by re-inspection in 12 months.

   d. If, on the basis of required focused re-inspection as required in 5)c.1, continued deficiencies exist, COPTI must declare:

      i. ‘Withdrawal of Accreditation’

6) A COPTI action of “withdrawal of accreditation” shall require an OPTI to make full reapplication for accreditation status and meet 70% of all accreditation Standards including all ‘must meet’ Standards.

7) A COPTI action of “accreditation with notice”, “accreditation with probation” and “withdrawal of accreditation” shall be reported to the PTRC, COPT, BOE and the commission on osteopathic college accreditation for information and record.
a. COPTI actions of “accreditation with probation” shall be reported to PTRC.

b. COPTI actions of “withdrawal of accreditation” shall be reported to PTRC with advice that programs academically sponsored by the OPTI must obtain another academic sponsor or close.

e. COPTI actions of ‘accreditation with probation’ or ‘withdrawal of accreditation’ shall be reported to the COCA with advice that another OPTI membership should be obtained (consistent with COCA Standards requiring each COM to hold an OPTI membership).

8) The COPTI has the authority to call for an on-site inspection outside of the 5 year accreditation cycle when it is necessary to preserve the quality of training for an individual OPTI and may also consider requests for off-cycle site visits by a member institution or other stakeholder.

9) COPTI has the authority to call for on-site inspection or other monitoring for an OPTI which undergoes substantive change(s) such as:

a. Any change in the legal status or control of the OPTI.

b. Mergers between OPTIS or dissolution of OPTI relationships resulting in multiple OPTIS.

e. Program change in academic sponsorship from one OPTI to another without notification of the AOA Department of Education PTRC and COPTI.

<table>
<thead>
<tr>
<th>Initial Provisional Accreditation</th>
<th>‘Must Meet’ Standards (6)</th>
<th>‘Regular Standards’ Found in Sections A and B</th>
<th>Action/Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Year</td>
<td>All ‘MM’ Met</td>
<td>All Standards In sections A and B must be met</td>
<td>Re-inspection in 1 year. All ‘MM’ must be met and conditions for full 5 year accreditation described below must be met (70% of all Standards). One additional year of provisional accreditation can be awarded by COPTI if necessary to facilitate/accommodate new OPTI formation issues.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accreditation action (5-year term)</th>
<th>‘Must Meet’ Standards (6/56)</th>
<th>‘Regular Standards’ (50/56)</th>
<th>Action/Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-Year Accreditation</td>
<td>All ‘MM’ met</td>
<td>&lt;11/ 50 unmet (at least 39 met=70% of 56 total Standards)</td>
<td>Cap with PR every 6 mos. All Standards must be corrected within 24 months.</td>
</tr>
<tr>
<td>Continuing 5 year</td>
<td>1 ‘MM’ unmet</td>
<td>&lt;11/50 unmet</td>
<td>Cap with PR every 6 mos. All Standards must be corrected within 24 months – ‘MM’ Standard must be corrected in 12 months.</td>
</tr>
<tr>
<td>5-year Accreditation with notice (private)</td>
<td>2 'MM' unmet on initial inspection</td>
<td>&lt;1/50 unmet</td>
<td>Cap with PR every 6 mos. Focused re-inspection in 12 months. If any 'mm' Standards remain unmet at 12 months, COPTI will assign the designation of 'accreditation with probation (public)'</td>
</tr>
<tr>
<td>All met</td>
<td>Any unmet at 24 months</td>
<td></td>
<td>Required focused site visit with revisit in 12 months. If any standards remain unmet at 36 months, COPTI will assign the designation of 'accreditation with probation (public)'</td>
</tr>
<tr>
<td>5-year Accreditation with probation (public)</td>
<td>Any unmet at 12 month focused visit</td>
<td>Any unmet AT 36 month focused visit</td>
<td>Required focused site visit in 12 months. If there are any remaining deficiencies, COPTI will take the action to 'withdraw accreditation'.</td>
</tr>
</tbody>
</table>

**Summary:**

The goal of OPTI accreditation is to assure the OGME trainee and the concerned public that osteopathic graduate medical education meets accepted standards of OGME quality. Likewise, such accreditation assures that programs sponsored by an accredited OPTI are producing OGME graduates that meet the AOA core competencies.

The above describes a method envisioned to streamline OPTI accreditation awards and to allow OPTIs to focus on quality measures rather than individual ‘points’ in a scoring rubric. The concept of ‘term accreditation’ allows freedom to focus on a OPTI's strategic plan, quality initiatives and matters of pedagogy in service to its members.

The concept of ‘term accreditation’ however must be accompanied by realization that certain standards are ‘must meet’ in character and as such form the basis of concern when deficiencies are identified.

The above set of policies attempt to address this concern in a way that allows correction in a timely way and serious consequences for an OPTI that does not come into compliance.

Under a ‘term accreditation’ concept there is the parallel concern with an OPTI that meets 70% of all Standards and also all ‘must meet’ Standards. Such an OPTI needs an appropriate time and plan to correct all deficiencies, but must do so in a reasonable timeframe. The proposed maximum 24 month timeframe assures the public that quality is both monitored and expected.

**FISCAL IMPACT:** $0

**ACTION TAKEN** _____________________

**DATE** ______________________________
RES. NO. B-9 A/2020 – Page 1

SUBJECT: REQUIREMENTS OF CME SPONSORS - CME SPONSORS CONFERENCE

SUBMITTED BY: Bureau of Osteopathic Education/ Council on Osteopathic Continuing Medical Education

REFERRED TO: AOA Board of Trustees

1 WHEREAS, the AOA Board of Trustees approved RES. NO B2-M/2019 titled “Requirements of CME Sponsors – CME Sponsors Conference” on February 28, 2019 to reinstate the CME Sponsors Conference; and

2 WHEREAS, the Resolution states that the CME Sponsors Conference be held jointly with the AOA Lead Conference to minimize the financial impact and that for those CME Sponsors not able to attend the conference be given access to view it online; and

3 WHEREAS, the affiliates are concerned about the timing and expense of the CME Sponsors Conference since some affiliates have their own CME events in late January and others are concerned about the cost of hotel and airfare in late January; and

4 WHEREAS, the Council on Osteopathic Continuing Medical Education (COCME) believes the Conference should not be tied to the AOA Lead Conference but rather the Council be given the flexibility to hold the conference with another AOA or osteopathic event; now, therefore be it

5 RESOLVED, that the that the Council on Osteopathic CME be given the flexibility to hold the Conference at other osteopathic events (e.g., AOA Annual/Mid-year Board of Trustees meetings, OMED, AOA osteopathic states conventions, and osteopathic specialty colleges events) that are less expensive and less costly than the current LEAD conferences..

Explanatory Statement:
The COCME believes that by allowing the CME Sponsors Conference to be held in conjunction will other osteopathic venues will allow more flexibility for providing information to the CME Sponsors on specific topics of interest.

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: ACCREDITOR NEEDS ASSESSMENT FOR AOA POLICY-SPECIFIC CONTINUING MEDICAL EDUCATION TOPICS

SUBMITTED BY: Bureau of Osteopathic Education / Council on Osteopathic Continuing Medical Education

REFERRED TO: AOA Board of Trustees

WHEREAS, the 2019 House of Delegates of the American Osteopathic Association (AOA) reaffirmed policy either “endorsing” or “encouraging” continuing medical education on the topics of Inhalation of Volatile Substances; Teenage Alcohol Abuse; and Training on Extended Release-Long Acting (ER/LA) Opioid Risk Evaluation and Mitigation Strategy (REMS); and

WHEREAS, accredited sponsors of AOA Category 1-A continuing medical education programs are required to conduct a needs assessment for all topics in a program in order to meet Category 1-A requirements; now, therefore be it

RESOLVED, that for topics for which the American Osteopathic Association has specific policy endorsing or encouraging continuing medical education, the required needs assessment conducted by accreditors need only refer to the specific AOA policy; and,

be it further

RESOLVED, that the AOA Council on Osteopathic Continuing Medical Education (COCME) publish for all AOA accreditors a list of topics for which the AOA has specific policy encouraging or endorsing continuing medical education, and that the list be updated annually following the adjournment of the House of Delegates meeting; and, be it further

RESOLVED, that the AOA COCME incorporate this policy into the Accreditation Requirements for AOA Category 1 CME Sponsors; and, be it further

RESOLVED, that the AOA COCME annually review and add topics as needed from the House of Delegates meeting.

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ____________________________
SUBJECT: REVISION TO BASIC STANDARDS FOR ORTHOPEDIC SURGERY

SUBMITTED BY: Bureau of Osteopathic Education / Council on Postdoctoral Training

REFERRED TO: AOA Board of Trustees

RESOLVED that the following Revisions to Basic Standards for Residency Training in Orthopedic Surgery be APPROVED.

( old material crossed out; new material in capital letters)

SECTION IV – INSTITUTIONAL REQUIREMENTS
4.1 The institution shall be required to have a minimum of four residents, within four (4) years of initial orthopedic surgery residency program approval.

SECTION V – PROGRAM REQUIREMENTS AND CONTENT
5.1 General Program Requirements:

5.1.2 The minimum size of the program shall be four (4) residents.

5.3 Specific requirements for training year OGME-R1: The first year (I) of the residency program’s general educational content shall include the listed rotation schedule. These shall be scheduled as 12 one-month rotations or 13 four-week rotations or any combination thereof.

5.3.1 Two months or rotations of internal medicine
5.3.2 One month or rotation of emergency medicine
5.3.3 Three months or rotations of general orthopedic surgery
5.3.4 One month or rotation of family practice
5.3.5 Two months or rotations of non orthopedic surgery such as vascular, general trauma, basic wound/burn/plastics, urology
5.3.6 Three months or rotations of electives upon approval of the program director selected from any of the following areas: general orthopedic surgery, foot and ankle, hand, hip and knee, shoulder and elbow, spine, sports medicine, pediatrics or pediatric orthopedics, anesthesiology, radiology
pain management
neurology
neurosurgery
physical medicine and rehabilitation
rheumatology

5.3.7—Supervision of the resident must be shared between the DME and the Orthopedic Program Director.

5.3.8—The resident must be introduced to and be made knowledgeable in the AOAO case log system for the logging of all orthopedic patient encounters.

SECTION VI – PROGRAM DIRECTOR / FACULTY QUALIFICATIONS AND RESPONSIBILITIES

Program Director Eligibility, Requirements, and Responsibilities:

... 6.3 Responsibilities

... 6.3.3 The Program Director shall provide a list of all new residents to the office of the AOAO within 30 days of each new program year.

SECTION VII – RESIDENT REQUIREMENTS

7.1 Candidates shall apply to the AOAO Evaluating Committee for advanced standing if the applicant has completed an AOA approved first year of training.

SECTION VIII – EVALUATION

... 8.12 Site Evaluation:

... 8.12.2 All newly approved programs, following the initial first year inspection, will have a focused site visit by an AOAO accredited orthopedic surgeon, to comprehensively evaluate and assist the program at the end of the third academic year. This will be provided and funded by the AOAO Evaluating Committee. This process is described in Appendix 1. The purpose of the focused site visit is to have the AOAO serve as a resource to the program to ensure the clinical and educational value of the program. This review is not intended to alter or change the terms of the accreditation status afforded to the program.

FISCAL IMPACT: 0
SUBJECT: REVISIONS TO AOA BASIC DOCUMENTS FOR POSTDOCTORAL TRAINING – OPTI ACCREDITATION STANDARDS


REFERRED TO: AOA Board of Trustees

WHEREAS, the Council on Postdoctoral Training requested the Council on Osteopathic Postdoctoral Training Institutions revise its standards and eliminate requirements not focused upon meeting immediate needs and those unlikely to change the outcome of resident training for programs under the AOA’s restricted accreditation after 6/30/20; and

WHEREAS, a survey was developed to get feedback from OPTI leaders on each OPTI standard and whether the standard should remain, be eliminated, be revised; and

WHEREAS, COPTI reviewed the results of the survey and the AOA Basic Documents for Postdoctoral Training – OPTI Accreditation Standards; now, therefore be it

RESOLVED, that the following Revisions to the AOA Basic Documents for Postdoctoral Training – OPTI Accreditation Standards be APPROVED.

(old material crossed out; new material in capital letters)

Section IV: Institutional Requirements for Osteopathic Graduate Medical Education

A. Institutional Requirements: Sponsoring OPTIs and Training Institutions

4.1.a. An OPTI seeking to academically sponsor an AOA-approved OGME program at a training institution must have been provisionally accredited at least 6 months or longer, preceding the date of approval of the training program(s).

4.3.b. The academic sponsor must declare accountability for compliance of training institutions with AOA policies including affiliation agreements, quality performance, trainee evaluations, and participation in on-site program reviews, corrective action plans, internal reviews and core competency compliance.

Section VI: Postdoctoral Leadership Requirements

E. Medical Education Committee (MEC)

6.2.b. The education committee shall include the DME, all program directors at the institution, patient quality assurance representative, administrative representation, OPTI REPRESENTATIVE, and peer-nominated trainee representatives;
Section IX. Standards for Accreditation of OPTIs

ALL AOA-APPROVED PROGRAMS UNDER THE RESTRICTED ACCREDITATION AUTHORITY OF THE AOA AFTER JULY 1, 2020 MUST BE UNDER THE ACADEMIC SPONSORSHIP OF AN OPTI. This section defines the accreditation standards against which OPTIs MUST MEET TO ACADEMICALLY SPONSOR AOA APPROVED PROGRAMS, are evaluated for accreditation by the AOA Council on Osteopathic Postdoctoral Training Institutions. The OPTI Accreditation Handbook documents the context and process used by the COPTI in accrediting OPTIs and provides supplementary statements of operations.

The AOA, COPTI and each accredited postdoctoral training facility are required to adhere to the policies, procedures and standards contained in these official AOA documents: Basic Documents for Postdoctoral Training and the OPTI Accreditation Handbook. These standards shall be used in conjunction with the Sections I-VIII of the AOA Basic Document for Postdoctoral Training.

Standards marked with a double asterisk (**) shall be considered a “must meet” standard. (See Appendix F of the OPTI Accreditation Handbook for additional information).

A. Prerequisites for Accreditation ORGANIZATION, GOVERNANCE AND FINANCE

9.1 ** OPTI shall be a formally organized entity.

9.2 ** OPTIs shall have at least one member hospital; all hospitals must be accredited or licensed.

9.2 ** OPTI shall include membership of at least one COM accredited by the Commission on Osteopathic College Accreditation (COCA) AND THE TRAINING INSTITUTION FOR EACH PROGRAM THAT IS UNDER THE ACADEMIC SPONSORSHIP OF THE OPTI.

9.4 ** OPTI by laws shall require each training institution supporting OGME to meet AOA institutional training standards for membership. See Section IV.A. and Glossary.

9.3 ** All member institutions of the OPTI must have an affiliation agreement with the OPTI.

9.4 The OPTI bylaws shall state that its members have the right to free association with other AOA-approved educational consortia, institutions or OPTIs.

9.7 ** Each established OPTI shall academically sponsor a minimum of two AOA approved residency programs, at least one of which is in the following specialties: family medicine, general internal medicine, obstetrics and gynecology, general surgery or general pediatrics.

9.8 ** Each OPTI shall include opportunities for osteopathic student clerkship experiences.

9.5 An institution that participates in an OPTI shall provide that OPTI with documentation it recognizes and accepts the certifying boards of the AOA as specialty board certification on an equal basis with those certifying boards recognized by the American Board of Medical Specialties (ABMS) for the purposes of obtaining hospital privileges.

B. Organization, Governance and Finance

9.1 ** The OPTI shall have defined, through strategic planning, its mission, goals, objectives, and outcomes.
9.2 The governing body of the OPTI shall define the organizational structure of the OPTI.

9.3 An OPTI shall collaborate with its member COM(S) to ensure a continuum of education for medical students and trainees.

9.3 The OPTI must declare in the by-laws or equivalent documents whether governance is through a direct or delegate representation for each OPTI member.

9.4 The OPTI's bylaws or equivalent documents shall require any member institution to notify the OPTI central site office of any substantive change that member has made.

9.5 The OPTI shall develop a reporting and communication process with all of its member institutions.

9.6 The OPTI must document site visits to MEANINGFUL INTERACTION WITH each training institution member no less than SEMI-annually by the OPTI CAO, Executive Director or administrative designee. See Section IV.A.

9.8 Each OPTI shall develop guidelines, policies and procedures that ensure the completion of an internal review at the midpoint between accreditation reviews for every OGME program in all training institutions. See Section IV.A. and Glossary.

9.7 The governing body shall ensure that its members and officers reveal and report conflicts of interest with respect to the affairs of the OPTI.

9.8 Each OPTI shall maintain a permanent and safe system for keeping governance, program accreditation, and resident program verification (including program complete certificates).

9.9 Each OPTI shall ensure that its educational program is under the direction and supervision of an OPTI Chief Academic Officer (CAO). The CAO shall be a DO who is AOA-board certified.

9.12 Each OPTI shall publish a list of academically sponsored programs at least annually and assist each program to review and update the AOA Opportunities webpage.

9.10 Each OPTI shall complete and forward to the AOA an annual report on a schedule set by COPTI but no later than October 1.

9.11 Each OPTI shall jointly confer, with its training institution(s), certificates of completion on those trainees who have satisfactorily completed the requirements for program complete status.

9.15 Each OPTI shall commit financial resources and define a financial plan and budget that is linked to its strategic plan.

C. Academic Sponsorship and Oversight

9.1 Each OPTI as the academic sponsor shall assist Specialty Colleges and training programs to comply with AOA policies, Basic Standards, and requirements for training program approval.

9.2 THE OPTI CAO OR DESIGNEE shall have an Osteopathic Graduate Medical Education (OGME) Committee to oversee the postdoctoral training program that meets at
least four times per academic year ATTEND AND PARTICIPATE IN EACH OF ITS
POSTDOCTORAL TRAINING PROGRAM'S MEC MEETINGS TO PROVIDE
OVERSIGHT TO THE PROGRAMS.

9.3 The OPTI OGME committee shall include the OPTI CAO, and representation from
institutional DMEs, residency program directors, faculty, trainees, and COMs.

9.3 A designated representative of the OPTI which academically sponsors a program shall
participate in the program and institution inspection review.

9.4 THE OPTI SHALL HAVE A REVIEW PROCESS FOR PROGRAM CORRECTIVE
ACTION PLANS, PROGRAM CHANGES IN LEADERSHIP (DME, PD), TRAINEE
COMPLAINTS, AND PROGRAM CLOSURES.

9.5 The OPTI OGME committee shall have a review process for program Corrective Action Plans
submitted by training institutions. The OPTI will have 30 days to review and approve the
Corrective Action Plan and forward the approved plan to the AOA.

9.6 The OPTI shall have a process to verify implementation of Corrective Action Plans within nine
months after the plan is acknowledged by the AOA and SPEC or IIEC. The OPTI will notify
the AOA of evidence verification and a record of the evidence of implementation of Corrective
Action Plans shall be kept on file with the OPTI.

9.7 The OPTI OGME committee shall review and approve each training institution’s core
competency plan.

9.8 Each OPTI OGME committee shall have an OPTI-wide uniform system of continuous
improvement in place that includes trainee submission of evaluation of their training programs.

D. Research and Scholarly Activity

9.1 Each OPTI shall require each member institution to establish policies and guidelines that
govern scientific research activities in accordance with local, state and federal guidelines.

9.1 Each OPTI shall facilitate and provide research education, assistance and resources directly to
trainees and institutions to encourage research and to meet the Specialty College requirements.

9.3 Each OPTI shall provide in collaboration with its member COM(S), hospitals and other
teaching institutions access to basic science and/or clinical research mentorship.

9.4 The OPTI shall support and provide a mechanism to recognize trainees who conduct research
activities.

9.5 The OPTI shall provide budgeted funding for OPTI-wide or program-specific research for its
trainees.

9.6 The OPTI shall demonstrate its support of trainee scholarly activity.

E. Faculty and Instruction

9.1 The OPTI shall have a documented process that demonstrates that faculty members are
credentialled or appointed at one or more COCA or LCME accredited colleges.

This template has been developed to provide the accepted guidelines for introduction of business
before the Board of Trustees and/or the House of Delegates. Please do not alter the template.
9.2 Operational documents must include faculty and administrative personnel non-discrimination policies in accordance with Section IV, F.4.6 of the AOA Basic Documents for Postdoctoral Training.

9.3 The OPTI shall delineate, in collaboration with its member COM(S), hospitals and other teaching institutions, a faculty development plan for core faculty and evaluate its effectiveness.

9.4 The OPTI shall ensure that a system exists to assess individual core faculty.

9.5 Each OPTI and its training institutions shall designate faculty to provide OPP teaching into its learning activities and patient care.

F. Trainee Status and Services

9.1 Each OPTI shall ensure the adoption of selection policies and criteria for trainees in accordance with the specific policies and procedures in the AOA Basic Documents for Postdoctoral Training.

9.2 Each OPTI shall ensure that transfer credit and waiver policies and procedures are applied in accordance with AOA policies.

9.1 Each OPTI shall have a system of trainee evaluation that measures and documents progress towards completion of the program including assessment of the AOA competencies.

9.2 Trainees shall be provided with a forum for free and open communication to discuss their training or welfare concerns. This forum should have voice through trainee representation on the OGME-MEC committee.

9.3 The OPTI shall have a system to monitor individual member institution’s work hour policies and activities and ensure they follow AOA guidelines.

9.4 The OPTI shall provide a means for trainees to report without reprisal, inconsistencies, violations, or disregard for published work hour policies to the OPTI through their designated representative on the OGME Committee.

G. Curriculum

9.1 The OPTI shall ensure that each program implements a curriculum specified by the specialty college or internship evaluating committee (IEC) that includes all seven AOA core competencies.

9.2 Each OPTI shall make curricular improvements based upon annual trainee evaluations of the program. Where specialty college evaluations are not available, the OPTI shall develop a method of internal evaluations.

9.3 The OPTI in collaboration with its member COM(S) shall facilitate the integration of OPP throughout all its AOA postdoctoral programs.

9.4 The OPTI monitor outcomes for each training Institution’s Core Competency Plan (ICCP) through annual reports to the OPTI OGME Committee.

9.5 The OPTI shall participate in the internal review process at each of its sponsored training programs.

This template has been developed to provide the accepted guidelines for introduction of business before the Board of Trustees and/or the House of Delegates. Please do not alter the template.
9.6 — The OPTI shall actively assist any sponsored program receiving less than a 71% site review compliance score.

9.7 — The OPTI shall have a process in place to assist in the development of new osteopathic programs in member institutions including but not limited to completion of program description, development of goal and objective-based curricula, and completion of required AOA accreditation documentation.

H. Facilities

9.1 — The OPTI shall coordinate with its member institutions to provide access to learning resources necessary for the delivery of the postdoctoral curricula.

9.2 — The OPTI shall coordinate with its member institutions to ensure library resources which are available 24/7. Support by professionally trained librarians shall be provided during normal business hours.

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________

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RES. NO. B-14 – A/2020 – Page 1

SUBJECT: PROPOSED AMENDMENTS TO AOA CONSTITUTION AND BYLAWS TO IMPLEMENT CHANGES TO GOVERNANCE STRUCTURE

SUBMITTED BY: Committee on AOA Governance and Organizational Structure

REFERRED TO: AOA Board of Trustees

1. WHEREAS, the AOA Board of Trustees approved certain changes to the governance structure at its midyear meeting; and

2. WHEREAS, in order to implement some of the changes approved by the Board of Trustees, it is necessary to amend the Constitution and Bylaws of the American Osteopathic Association; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) Board of Trustees (BOT) approve the proposed changes to the AOA Constitution and Bylaws; and, be it further

RESOLVED, that upon approval by the BOT the proposed changes to the AOA Constitution and Bylaws be submitted to the AOA House of Delegates for consideration.

Old information strikethrough | New information CAPS

Section 2 - Executive Committee. The Executive Committee of this Association shall consist of the President, President-elect, Past Presidents for the preceding two years, the chairs of the Departments of Affiliate Relations, FINANCE Business Affairs, EDUCATION Educational Affairs, Governmental Affairs, MEMBERSHIP Professional Affairs, and Research, Quality and Public Health.

1. AOA Constitution, Article VIII (Board of Trustees and Executive Committee),

2. AOA Bylaws, Article IX - Departments, Bureaus, and Committees

The Board of Trustees and House of Delegates, consistent with the powers given to it by these Bylaws, shall establish and determine the duties of departments, bureaus, councils, commissions, committees, and task forces necessary to further the policies of the Association. The Association’s departments shall include the Departments of Affiliated RELATIONS Affairs, FINANCE Business Affairs, EDUCATION Educational Affairs, Governmental Affairs, MEMBERSHIP Professional Affairs, and Research, Quality & AND Public Health. The activities of all departments, bureaus and committees shall, so far as possible, be executed in close cooperation with the Chief Executive Officer. Upon the expiration of the terms of office of chairs and members of the departments, bureaus, or committees, all records of the same shall be delivered by the chairs to the Chief Executive Officer. All employed staff of departments, bureaus, and committees in the offices shall be under the jurisdiction of the Chief Executive Officer.
3. AOA Bylaws, Article II (Membership), Section 2 - Membership Requirements
   a. Applicants for Regular Membership . . . . Such information and application shall be
carefully reviewed by the BUREAU OF Committee on Membership, which shall make an
appropriate recommendation for reinstatement to the Board of Trustees. An applicant
whose license to practice is revoked or suspended, or who is currently serving a sentence
for conviction of a felony offense, shall not be considered eligible for membership in this
Association.

   b. Honorary Life Member . . . . Honorary life membership may also be conferred by the
Board of Trustees on a regular member who has been in good standing for 25 consecutive
years immediately preceding, and who has rendered outstanding service to the profession at
either the state or national level, or who is recommended for such a membership by official
action of his divisional society and the BUREAU OF Committee on Membership. Such
honorary life members shall have the privileges and duties of regular members including the
payment of assessments levied by the Association, but shall not be required to pay dues.

   c. Life Member . . . . The BUREAU OF Committee on Membership may waive this
requirement on individual consideration. Such members shall have the privileges and duties
of regular members, but shall not be required to pay dues or assessments beginning the year
AOA Constitution & Bylaws 6 in which the age of 70 is attained.

4. AOA Constitution, Article IX – Amendments
   This Constitution may be amended by the House of Delegates at any annual meeting by a
two-thirds vote of the total number of delegates accredited for voting, provided that such
amendments shall have been presented to the House and filed with the Chief Executive
Officer at a previous annual meeting, who shall cause them to be distributed by US MAIL,
OR ELECTRONIC first class mail, postage prepaid, to each divisional and specialty society
entitled to and voting representatives to the house of delegates, posted on the AOA’s
website, and published in the ON-LINE EDITION OF THE Journal of the American
Osteopathic Association not less than two months Nor more than four months prior to the
meeting at which they are to be acted upon.

5. AOA Bylaws, Article XI – Amendments Section 1 – Bylaws
   These Bylaws may be amended at any annual or special meeting of the House of Delegates
by a two-thirds vote of the total number of delegates accredited for voting, provided that
the amendment shall have been filed with the Chief Executive Officer at least two months
before the meeting at which the amendment is to be voted upon. Upon receiving a copy of
the amendment, it shall be the duty of the Chief Executive Officer to cause it to be
distributed by US MAIL OR ELECTRONIC first class mail, postage paid, to each
divisional and specialty society entitled to send voting representatives to the House of
Delegates, posted on the AOA’s website, and published in THE ON-LINE EDITION OF
The Journal of the American Osteopathic Association at least one month before the
meeting. The Board of Trustees may revise the proposed amendment if necessary to secure
conformity to this Constitution and Bylaws and shall then refer it to the House for final
action not later than the day prior to the end of the meeting.
Explanatory Statement:

FISCAL IMPACT: $0

ACTION TAKEN __________________________

DATE _________________________________
RESOLVED, that the American Osteopathic Association (AOA) Board of Trustees (BOT) approve the proposed changes to the AOA Constitution and Bylaws; and, be it further

RESOLVED, that upon approval by the BOT the proposed changes to the AOA Constitution and Bylaws be submitted to the AOA House of Delegates for consideration.

1. AOA Bylaws, Article II (Membership), Section 2-Membership Requirements

   a. Applicants for Regular Membership . . . . Such information and application shall be carefully reviewed by the BUREAU OF Committee on Membership, which shall make an appropriate recommendation for reinstatement to the Board of Trustees. An applicant whose license to practice is revoked or suspended, or who is currently serving a sentence for conviction of a felony offense, shall not be considered eligible for membership in this Association.

   b. Honorary Life Member . . . . Honorary life membership may also be conferred by the Board of Trustees on a regular member who has been in good standing for 25 consecutive years immediately preceding, and who has rendered outstanding service to the profession at either the state or national level, or who is recommended for such a membership by official action of his divisional society and the BUREAU OF Committee on Membership. Such honorary life members shall have the privileges and duties of regular members including the payment of assessments levied by the Association, but shall not be required to pay dues.

   c. Life Member . . . . The BUREAU OF Committee on Membership may waive this requirement on individual consideration. Such members shall have the privileges and duties of regular members, but shall not be required to pay dues or assessments beginning the year in which the age of 70 is attained.
Explanatory Statement:

FISCAL IMPACT: $0

ACTION TAKEN _______________________

DATE ______________________________
SUBJECT: PROPOSED AMENDMENTS TO AOA CONSTITUTION AND BYLAWS TO UPDATE MECHANISM FOR AMENDING THE CONSTITUTION AND BYLAWS

SUBMITTED BY: Committee on AOA Governance and Organizational Structure

REFERRED TO: AOA Board of Trustees

1. WHEREAS, the American Osteopathic Association (AOA) Committee on AOA Governance and Organizational Structure has reviewed and discussed the AOA’s Constitution and Bylaws; and

2. WHEREAS, it is noted that the current mechanism for notifying members and affiliated organizations of proposed amendments to the AOA’s Constitution and Bylaws does not permit use of electronic communication and references the published version of the JAOA - Journal of the American Osteopathic Association; and

3. WHEREAS, the CAGOS believes that these mechanisms for providing notice to members and affiliated organizations should be updated to allow for use of electronic communication and online publication; now therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) Board of Trustees (BOT) approves the proposed changes to the AOA Constitution and Bylaws; and, be it further

RESOLVED, that upon approval by the BOT the proposed changes to the AOA Constitution and Bylaws be submitted to the AOA House of Delegates for consideration.

Old information **strike through** | New information **CAPS**

1. AOA Constitution, Article IX - Amendments
   This Constitution may be amended by the House of Delegates at any annual meeting by a two-thirds vote of the total number of delegates accredited for voting, provided that such amendments shall have been presented to the House and filed with the Chief Executive Officer at a previous annual meeting, who shall cause them to be distributed by US MAIL OR ELECTRONIC first class mail, postage prepaid, to each divisional and specialty society entitled to and voting representatives to the house of delegates, posted on the AOA’s website, and published in the ON-LINE EDITION OF THE Journal of the American Osteopathic Association not less than two months nor more than four months prior to the meeting at which they are to be acted upon.

2. AOA Bylaws, Article XI - Amendments Section 1--Bylaws
   These Bylaws may be amended at any annual or special meeting of the House of Delegates by a two-thirds vote of the total number of delegates accredited for voting, provided that the amendment shall have been filed with the Chief Executive Officer at least two months
before the meeting at which the amendment is to be voted upon. Upon receiving a copy of the amendment, it shall be the duty of the Chief Executive Officer to cause it to be distributed by US MAIL OR ELECTRONIC first-class mail, postage paid, to each divisional and specialty society entitled to send voting representatives to the House of Delegates, posted on the AOA’s website, and published in THE ON-LINE EDITION OF The Journal of the American Osteopathic Association at least one month before the meeting. The Board of Trustees may revise the proposed amendment if necessary to secure conformity to this Constitution and Bylaws and shall then refer it to the House for final action not later than the day prior to the end of the meeting.

Explanatory Statement:

FISCAL IMPACT: $0

ACTION TAKEN ________________________

DATE _____________________________
RESOLVED, that the following actions taken at the Executive Committee meetings on March 7, March 11, April 14, May 12, and June 9, 2020, be APPROVED:

March 7, 2020
• Approval to Cancel DO Day

March 11, 2020
• Approval of a motion to authorize AOA staff to further evaluate litigation against the American Board of Internal Medicine (ABIM)
• Approval of RES NO. EC1 - AOBNMM Board Nomination
• Approval of the BOS Policies for open comment

April 14, 2020
• Approval of Res NO. EC1 Proposed Amendments to the Constitution and Bylaws of the Texas Osteopathic Medical Association with edits as discussed in the meeting.

May 12, 2020
• Approval of Res NO. EC1 Nominations to Membership on Specialty Boards.
• Approval of the Special Session for the 2020 Annual Business Meeting/House of Delegates Meeting in October.
• Approval to move forward with final determination of the JAOA Publishing Partner.

June 9, 2020
• Approval of Res NO. FC1 Proposed AOA FY2021 Operating Budget
• Approval of Res NO. FC2 Proposed AOA FY2021 Capital Expenditures Budget.
• Approval of Res NO. EC1 AOBFP OCC Component 2.
• Approval of Res NO. EC2 Changes to Assist Osteopathic Physicians and the AOA Category 1 CME Sponsors as a Result of COVID-19 Pandemic.
• Approval of Nominees to the NBOME Board of Directors.
Explanatory Statement:
The minutes of each meeting are posted to the AOA Board of Trustees secured online workspace.

ACTIONS TAKEN ____________________________

DATE ____________________________
CONSENT AGENDA – FOR COLLECTIVE ACTION BY THE FULL BOARD OF TRUSTEES

Mr. President, the Committee on Basic Documents & Operations of Affiliated Organizations met on June 24, 2020, to review requests related to various affiliated organizations.

I now present for consideration the following consent agenda and the Committee recommends that it be APPROVED:

1. American Association of Osteopathic Examiners (Amended Bylaws)
2. American College of Osteopathic Pediatricians (Amended Bylaws)
4. Idaho Osteopathic Physician Association (Amended Bylaws)
5. Kentucky Osteopathic Medical Association (Amended Bylaws)
6. Maine Osteopathic Association (Amended Bylaws)
7. Oklahoma Osteopathic Association (Amended Bylaws)
And I so move.

Mr. President, this concludes the Committee’s report. I would like to thank the following members Reference Committee for their collaboration and hard work.

**Committee Members**
- Ray L. Morrison, DO, Chair
- Robert W. Hostoffer, DO, Jr., Vice Chair
- Robert S. Dolansky, DO
- Jennifer Hauler, DO
- Sonia Rivera-Martinez, DO
- Joseph M. Yasso, Jr. DO
- Frank Goodman, DO
- Willie M. Jones, DO

**Staff**
- Yolanda Doss, MJ
- Josh Prober, JD