



## REPORT OF THE PRESIDENTIAL TASK FORCE ON SELECTION OF AASM BOARD OF DIRECTORS AND OFFICERS

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# SUMMARY OF TASK FORCE RECOMMENDATIONS

## **I. Historical Review**

- There has been major growth in the activities of the organization along with growth in membership, accredited centers and revenues.
- The activities of the organization are in-line with its stated mission.
  - AASM is active in all of the areas of its Strategic Goals: Clinical, Advocacy, Education, Research and Organizational Effectiveness.
  - The current distribution of activities matches the distribution suggested by the membership survey.
  - Considerable and appropriate resources have been devoted to promoting the Clinical, Advocacy, Education, Research and Organizational Effectiveness Strategic Goals.
- The composition of the Board of Directors has reflected the diversity of the membership and the Strategic Goals of the organization.
  - The distribution of Clinical, Academic/Research and Academic/Clinician Educators has been appropriate for the activities of the organization. Over the last decade there has been an increase in Academic/Clinician Educator Directors and a decrease in Academic/Research Directors.
  - A diversity of specialty backgrounds has been maintained on the Board of Directors. Over the last decade there has been an increase in the number of Directors with a pulmonary background and a decrease in those with a psychiatry background consistent with the composition of the membership.

## **II. The Nominating Process**

- Currently, the Nominating Committee (Past President, President and President-elect) recommends a slate of candidates for Director positions and Officers to the Board of Directors. The BOD approves the slate and the candidates are submitted to the membership for ratification.
- A review of the election practices of 32 other medical organizations found that 44% had contested elections, 41% did not have contested elections, 9% had variable types of elections and 6% did not provide information. All used Nominating Committees to recommend candidates. In the overwhelming majority of cases the Nominating Committee was comprised of Officers/Directors plus members external to the Board of Directors.

## **III. Task Force Recommendations for the Nominating Process**

- Despite the positive outcome of the current system, the Task Force felt the nominating process would be improved by adding external members to the Nominating Committee in order to increase input from the membership and increase transparency of the process.
- The Nominating Committee should be composed of five individuals to include: the President, Past President, Past Past President and two AASM members-at-large.
- The Nominating Committee will make recommendations on both Officers (President-elect and Secretary-Treasurer) and new Directors.
- The two AASM members-at-large will be elected by the membership of the AASM and will each serve a two-year term.
  - Self-nomination for these positions will be permitted.
  - The terms of the at-large members will run for two term years, defined from the June SLEEP meeting to the next SLEEP meeting, the same as for the Board of Directors.
  - Terms will be staggered, with one at-large member elected each year.
  - The election of at-large members will occur at the same time as the election for the Board of Directors and Officers.
  - If no single member has > 50%, then the at-large member will be determined by a runoff election of the top 5 vote getters and the winner decided by plurality.

- **The eligibility requirements to serve as an at-large member are as follows:**
  - **At least 5 years membership in the AASM**
  - **The nominee must have either served on an AASM Committee or is an active member of an AASM Section.**
  - **The at-large member must meet the same conflict of interest standards as required of the AASM Board of Directors.**
- **The Nominating Committee should continue to promote diverse representation of the membership. The Committee should seek to restore and maintain a more even balance of academic (research and clinician educator) and clinical directors and a balance of sleep disciplines. The sleep disciplines should be based on broad areas of interest (behavioral/psychiatric sleep disorders, childhood sleep disorders and development, movement/neurologic sleep disorders, cardiorespiratory sleep disorders) rather than primary specialties.**
- **The election should continue to be a candidate-slate election process.**
- **The task force recommends that the Board of Directors reevaluate the effect of these changes in 5-10 years.**

#### **IV. Conflict of Interest Policy**

- **The current AASM Conflict of Interest policy is appropriate.**
- **Potential Directors have the opportunity to resolve potential conflicts if they are interested in serving in a leadership position.**

### **BACKGROUND**

The procedure for selection of the members of the Board of Directors and officers of the American Academy of Sleep Medicine was established in the Bylaws of the organization. The Nominating Committee, comprised of the President, President-elect and Immediate Past President, proposes a slate of nominees for the positions of President-elect, Secretary Treasurer and Directors. The slate is approved or modified by the full Board of Directors then put to a vote of the general membership for ratification.

In December, 2007, the President of the AASM received a letter from 45 members expressing concern over some of the policies of the Academy. Among them was a concern that the ability of the organization to respond to the current challenges faced by the field was limited by the current AASM governance structure. They suggested this problem could be addressed by increasing the involvement of leading investigators and opinion leaders in different aspects of sleep and its disorders in the leadership of the AASM and increasing input from membership into the Board selection process.

In response, M. Susan Esther, M.D., President of the AASM, established a presidential task force in July of 2008. The task force's mandate was to review the current AASM bylaws, policies and procedures for selection of candidates for nomination to the Board of Directors and their subsequent election. This review was to take into consideration: overall performance of the organization in meeting the needs of the membership, qualifications and experience required to serve on the board or as an officer of the AASM and levels of conflict of interest that are acceptable.

### **TASK FORCE METHODOLOGY**

The task force held monthly conference calls from August 2008 through January 2009. The task force reviewed the finances of the AASM and examined the relationship between the goals of the organization and distribution of resources. The task force reviewed the composition of the Board of Directors over the last 10 years with regard to primary specialty and academic status. A survey of the election procedures of 32 American Medical Association (AMA) membership organizations was performed by the AASM staff under the direction of the task force.

After review of all the available data the task force produced a series of consensus statements regarding the current status of the AASM. Based on their understanding of the current electoral process, the task force developed consensus recommendations for future elections. All consensus statements were passed unanimously.

## TASK FORCE REVIEW

### *Organization Activities*

Over the last 10 years there has been considerable growth in both the field of sleep medicine and the AASM. AASM individual membership has almost tripled, center membership has grown sevenfold and the number of accredited centers has more than tripled (see figures 1, 2 and 3). In addition, the AASM provides management services for 7 other organizations including the Sleep Research Society, the American Academy of Dental Sleep Medicine and the American Association of Sleep Technologists (see appendix 1 for the complete list).

Figure 1

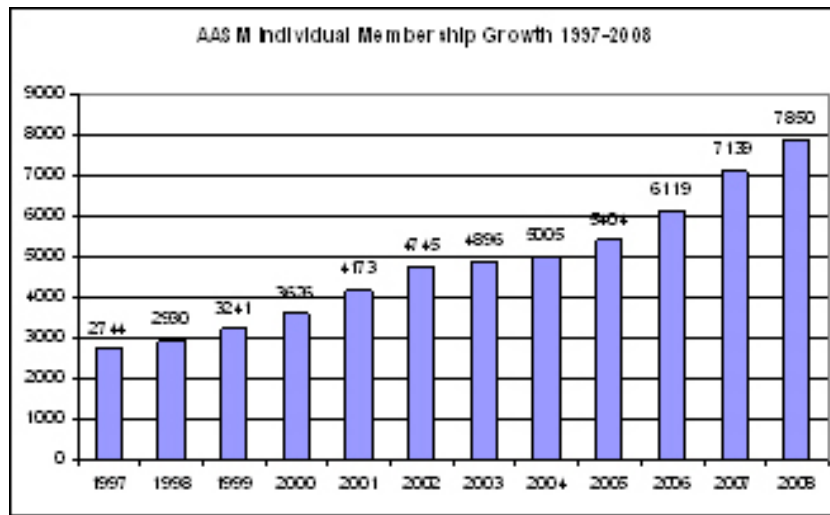


Figure 2

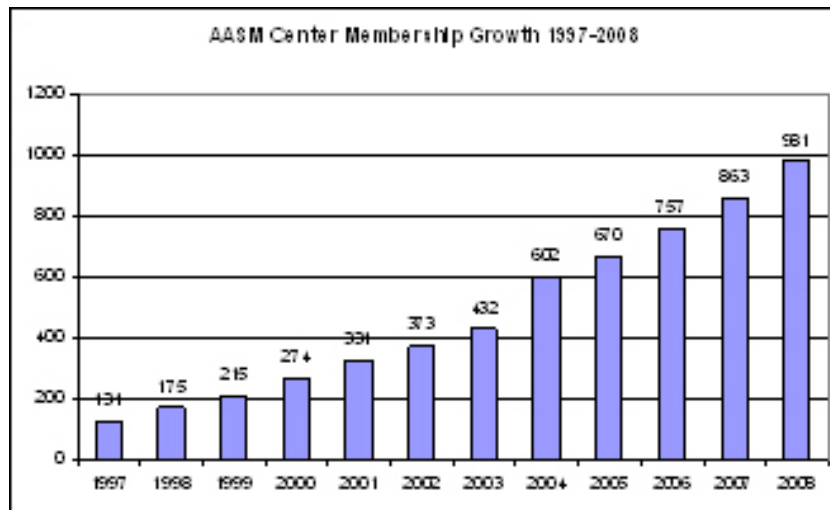
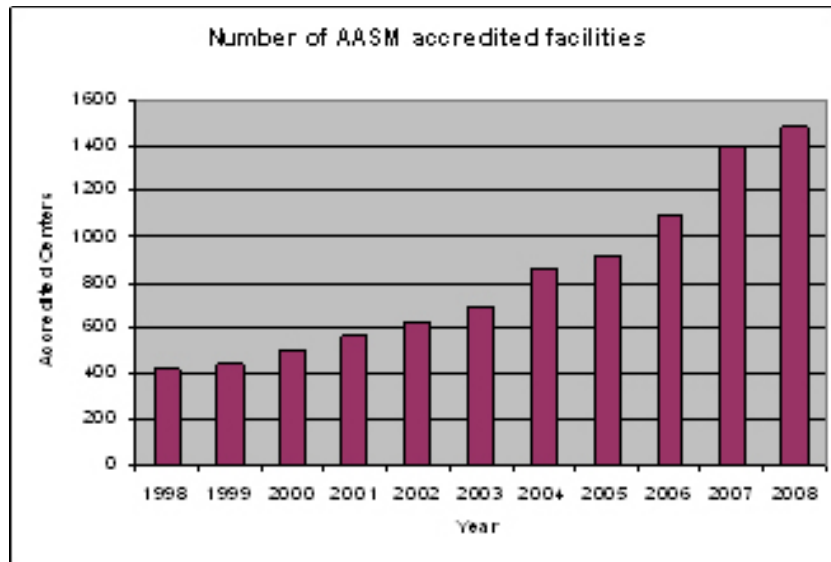


Figure 3



As a result, there has been an increase in the revenues of the AASM (see figure 4). The variety of services has allowed a diversification in revenue sources such that no more than 20% comes from any one revenue source (see figure 5). The AASM Board of Directors oversees the operations of the organization and directs its activities.

Figure 4

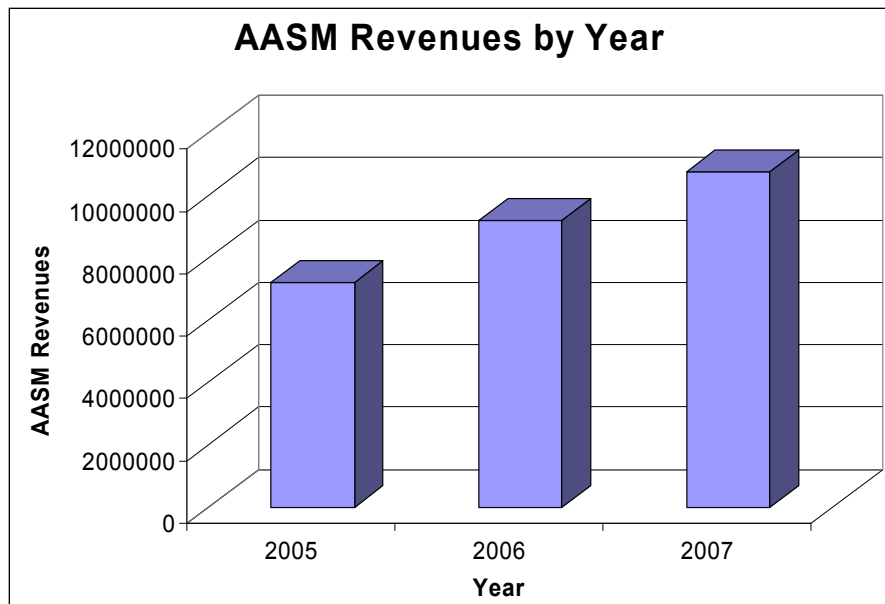
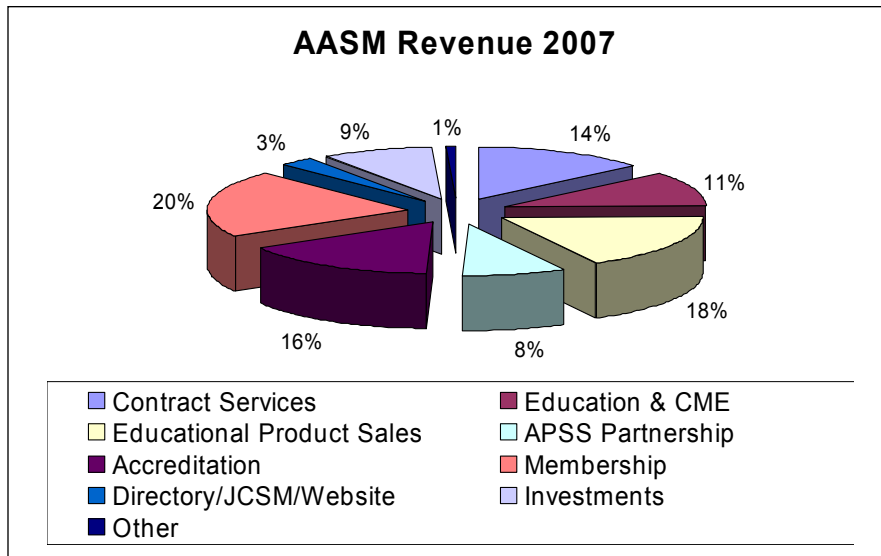


Figure 5

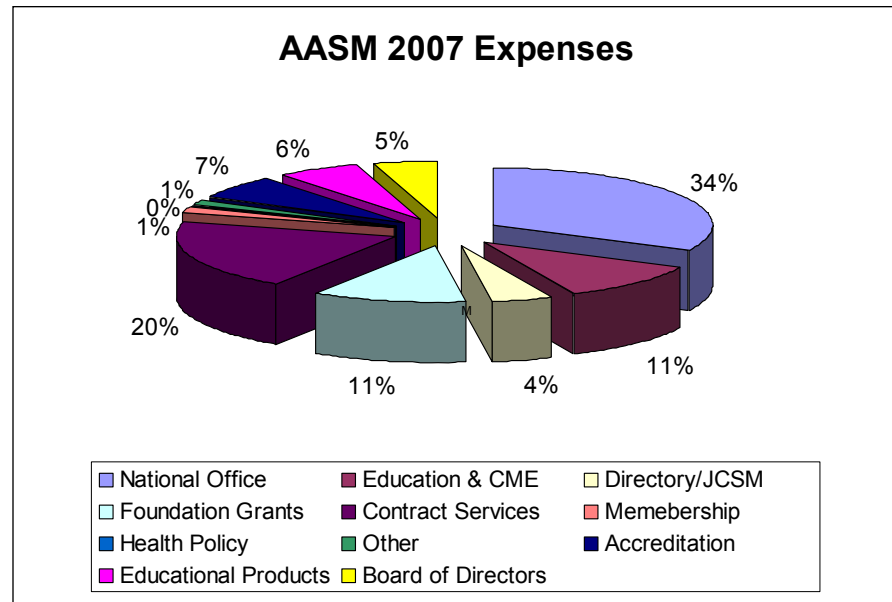


The AASM Board of Directors initiates and carries out policies according to the strategic goals of the AASM Strategic Plan. The current Board is operating under the Strategic Plan developed in 2001 and updated in 2005 and 2008. The strategic goals of this plan are listed in the appendix 2. After development of the initial Strategic Plan, the membership was surveyed as to the relative importance of the different strategic goals. Members rated each goal on a scale from very important to unimportant. The percentage of the membership that considered each strategic goal to be very important is shown in Table 1. The entire membership survey can be seen in appendix 3.

Strategic Goal	% Very Important
AASM will be the leading advocate of health policy and health economic issues important to Sleep Medicine	73
AASM will be the leading organization setting standards and meeting professional and patient needs in Sleep Medicine so that patients are most effectively diagnosed and treated	67
Sleep Medicine will be widely recognized as an independent medical specialty	62
AASM will be the most effective sleep medicine organization in meeting the needs of its members	56
AASM will be the leading advocate for research in Sleep Medicine	46
AASM will be the pre-eminent resource for professional and public education in Sleep Medicine.	44

The activities of the Board of Directors have been oriented towards fulfilling these strategic goals. The allocation of resources to the different activities is reflected in the overall expenses (see figure 6) of the organization. The largest expenditure, for the National Office, covers the organization's expenses including personnel, office rent and equipment and infrastructure. The diversity of the expenses reflects the multiple strategic goals and can be categorized as clinical, educational, advocacy, research and organizational.

Figure 6



Clinical-related activities include the development and production of practice parameters, clinical guidelines and pay for performance standards. The AASM accredits sleep centers and sleep laboratories, promoting high-quality care. The Academy works with third party payors to develop sleep medicine guidelines and policies. Working with other professional organizations and the general public, the AASM promotes Sleep Medicine as an independent field and Sleep Technology as an independent allied health profession.

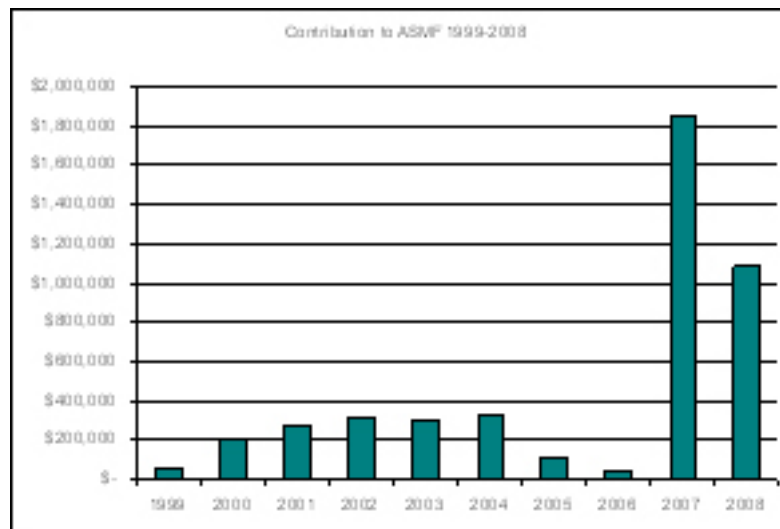
Education-related activities include offering courses and seminars and supporting training of sleep medicine professionals and sleep technologists. The AASM cosponsors and runs the annual SLEEP meeting and puts on multiple topic-related courses and webinars. The AASM creates and produces slide sets and patient brochures. AASM educational products also include the International Classification of Sleep Disorders and the AASM Manual for the Scoring of Sleep and Associated Events: Rules, Terminology and Technical Specifications. In order to promote training of new sleep professionals, the AASM supported of the establishment of Accreditation Council of Graduate Medical Education (ACGME) sleep medicine fellowships and accredits Behavioral Sleep Medicine fellowship programs. The Fellowship Training Committee of the AASM develops materials for the sleep medicine fellowships. The AASM promotes the establishment of sleep medicine academic units and, to foster this policy, has become a member of the Association of American Medical Colleges and has developed the Comprehensive Academic Sleep Program of Distinction award. The Accredited Sleep Technologist Education Program (ASTEP) was created by AASM to improve the educational level of sleep technologists and the AASM is a participant in creating college-based training programs for technologists through its participation in the Committee on Accreditation of Polysomnographic Technology Education Programs (CoA PSG).

AASM advocacy efforts cover a spectrum from legislation and reimbursement to political action. The Health Policy Committee monitors regulatory activity and reimbursement policy. At the direction of the Board of Directors, the AASM participates in the development of coding and reimbursement policy with government agencies and insurance providers. Most recently, this has resulted in the development of new policies regarding the use of portable monitors for home sleep testing. The AASM Political Action Committee assists legislators supportive of the sleep field. In order to maintain an adequate supply of well-trained sleep technologists, the AASM has been involved with state legislatures to promote and protect the field of sleep technology. AASM is working with local sleep professionals to develop state sleep societies in every state.

The AASM is involved in multiple research related activities. The AASM is a cosponsor of the premier sleep science meeting and promotes new investigators at the meeting with its Young Investigator Awards. Two sleep science journals are produced by the AASM, SLEEP (co-published with SRS) and the Journal of Clinical Sleep Medicine.

AASM actively advocates for sleep research with the National Institutes of Health (NIH) and this year sponsored a Young Investigators Research Forum at NIH. Considerable resources have been allocated by the AASM to the American Sleep Medicine Foundation (ASMF) to promote sleep research (see figure 7). Originally called the Sleep Medicine Research and Education Foundation, the ASMF was created to support clinical, basic and educational research. The first ASMF grants were awarded in 2000. Since then, the ASMF has awarded nearly \$3 million to 37 projects. Almost the entire funding for these grants came from the AASM. In addition, the AASM provides all administrative support to the ASMF at no cost to the ASMF, assuring all ASMF funds go towards research projects. The ASMF has 3 major research funds. The General Fund is supported by a yearly AASM contribution, averaging \$360,000. The AASM Endowment Fund was started with a \$1 million AASM contribution in 2007 with the goal of increasing the fund to \$5 million. The third fund is the American Board of Sleep Medicine (ABSM) Endowment Fund which was created in 2007 with a \$2 million contribution from ABSM. These funds support Physician Scientist Training Awards, Junior Faculty Research Awards and Strategic Research and Educational Projects such as the current \$800,000 multi-center, randomized controlled trial of portable monitoring for the diagnosis of obstructive sleep apnea.

Figure 7  
AASM contributions to ASMF.



Ongoing efforts to improve the effectiveness and efficiency of the AASM as a membership Society include the restructuring of the organization to create and promote disease oriented Sections (see appendix 4) and programs to improve the education and skills of the Academy staff. Investment in infrastructure has allowed expansion of the utilization of online resources. The Academy website has been updated to be more user friendly and improve communication between the membership and the leadership by creating discussion forums and interest group message boards. A second general public-oriented website has been added; [sleepeducation.com](http://sleepeducation.com).

Based on its review of the organizational data the Task Force reached the following conclusions:

- There has been major growth in the activities of the organization along with growth in membership, accredited centers and revenues.
- The activities of the organization are in-line with its stated mission.
  - o AASM is active in all of the areas of its Strategic Goals: Clinical, Advocacy, Education, Research and Organizational Effectiveness.
  - o The current distribution of activities matches the distribution suggested by the membership survey.
  - o Considerable and appropriate resources have been devoted to promoting the Clinical, Advocacy, Education, Research and Organizational Effectiveness Strategic Goals.



## Election Process

The current election process was established by the AASM bylaws. The Nominating Committee proposes a slate of candidates for the Board of Directors and the board Officers. The slate is approved by the Board of Directors and ratified by a vote of the general membership. The Past President, President and President-elect serve as the members of the Nominating Committee. Before considering any changes to this process the task force investigated the effect this process has had on the composition of the Board of Directors and election process options followed by other professional organizations.

Sleep Medicine has evolved into an independent medical specialty with contributions from multiple fields including neurology, psychiatry, internal medicine, pulmonary medicine, otolaryngology, pediatrics, family practice and behavioral psychology. This diversity has contributed to the rapid development of the field. The influx of clinicians from the variety of specialties has affected the distribution within the membership. Two trends over the last decade have been an increase in the number of members with a background in pulmonology and an increase in the number who identify themselves predominantly as sleep specialists. The current composition of the AASM membership is shown in figure 8.

Figure 8

Specialty	# in Specialty	% of Membership
Internal Medicine (Pulmonary, Critical Care)	2901	34.8%
Sleep Medicine	2631	31.6%
Neurology	1268	15.2%
Psychiatry	400	4.8%
Otolaryngology	374	4.5%
Pediatrics	340	4.1%
Psychology	289	3.5%
Family Practice	165	2.0%
Total	8368	100.3%

Percentage total greater than 100%, due to members reporting multiple specialties.

<b>Total AASM Members:</b>	<b>8339</b>
Number who Reported Specialty Data:	7019
% Reported:	84.2%
Data as of 1/14/09	

According to the Executive Director of the AASM, it has been the policy of the Board of Directors to try to maintain a diversity on the board that was reflective of the composition of the membership. The Task Force reviewed the primary specialty of all the Directors over the last decade. As shown in figures 9 and 10, the board has maintained a diversity of primary specialties with a trend to an increase in those with a pulmonary background and a decrease in those with a psychiatry background. This was in part accommodated by an increase in the size of the Board of Directors from 10 to 12 Directors in 2002.

Figure 9

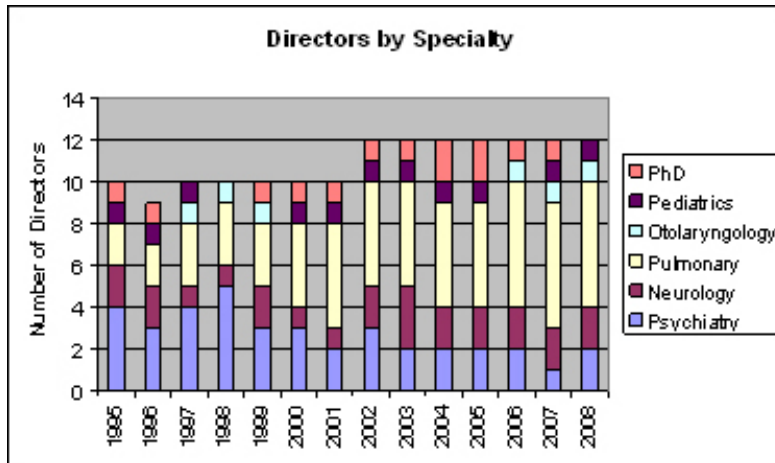
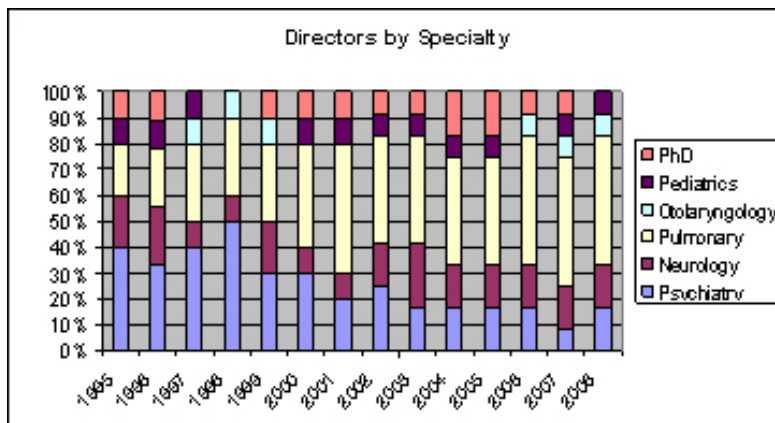


Figure 10



In addition to a diversity of specialties, the Board of Directors has sought to maintain a diversity of academic backgrounds. To fully represent the field, they felt there needed to be representation from researchers, educators and clinicians. The Task Force reviewed the academic background of the Board of Directors for the last decade. The task force established 3 categories: Academic/Research, Academic/Clinician Educator and Clinical. The following definitions were used to categorize an individual's academic background.

- Academic/Research: Academic appointment and either a history of NIH funding by CRISP Report or > 20 peer reviewed articles on PubMed (no reviews, editorials)
- Academic/Clinician Educator: Academic appointment and either > 10 PubMed referenced articles or involvement with an accredited training program (program director, faculty)
- Clinical: Predominantly clinical practice or not meeting criteria for the academic categories.

The composition of the Board of Directors has maintained a diversity of academic backgrounds for the last decade. There has been an increase in Academic/Clinician Educator Directors and a decrease in Academic/Research Directors (see figures 11 and 12).

Figure 11

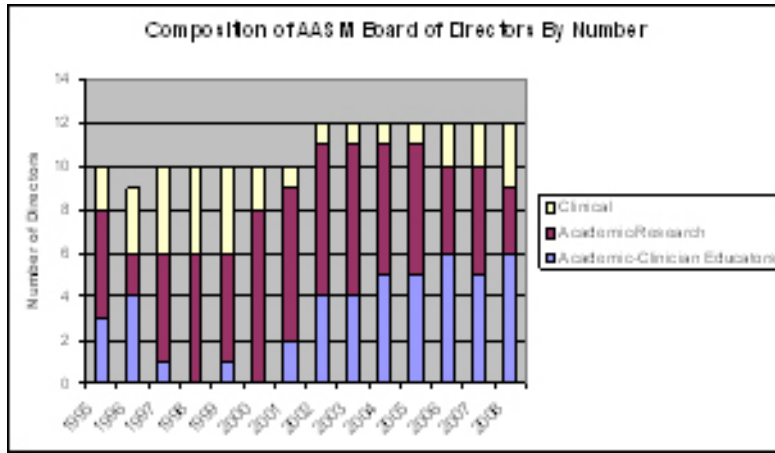
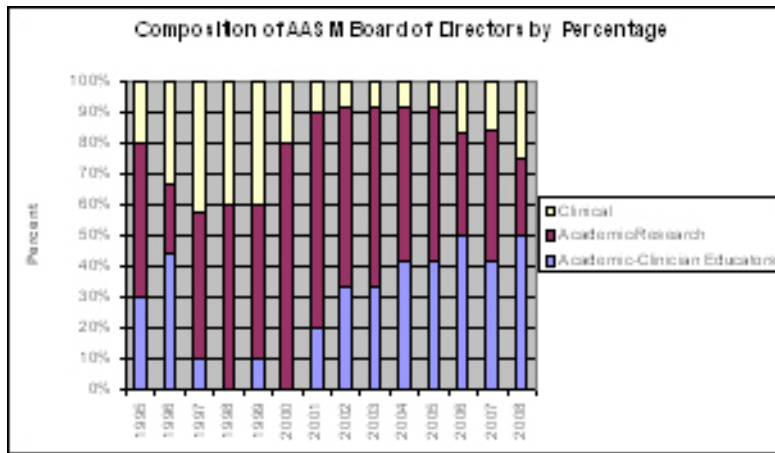


Figure 12



Based on its review of the investigational data the Task Force reached the following conclusions:

- **The composition of the Board of Directors has reflected the diversity of the membership and the Strategic Goals of the organization.**
  - o **The distribution of Clinical, Academic/Research and Academic/Clinician Educators has been appropriate for the activities of the organization. Over the last decade there has been an increase in Academic/Clinician Educator Directors and a decrease in Academic/Research Directors.**
  - o **A diversity of specialty backgrounds has been maintained on the Board of Directors. Over the last decade there has been an increase in the number of Directors with a pulmonary background and a decrease in those with a psychiatry background consistent with the composition of the membership.**

The Task Force next investigated alternate election procedures. At the request of the Task Force, the AASM staff contacted 32 other medical societies within the AMA and requested information on their election processes. Information was requested on the size of the organization, the size of the Board of Directors, the size and composition of their Nominating Committee, their election process and whether or not they had contested elections. The full results of the survey are found in appendix 5. The largest number of organizations, 44%, had contested elections, while 41% did not have contested elections, 9% had variable types of elections and 6% did not provide information. All of the organizations have a Nominating Committee that recommends candidates. The size of the Nominating Committee ranges from 5-13 members. All had current and past Board members on the Nominating Committee and members external to the Board of Directors as well.

The task force debated the advantages and disadvantages of the various election models. The advantages of the current system were that it had resulted in the AASM constructing and implementing a successful strategy for advancing the field and growing a successful organization and produced diversity in specialty representation and academic background on the Board of Directors. The current model maximizes the input of a successful Board of Directors in selecting new Directors likely to continue in a similar direction. The disadvantages of this model include reduced transparency in the selection process and the possibility of excluding a broader range of input. At the other end of the spectrum is a model with open nominations and contested elections. The advantages of this model are increased transparency and greater possibility for broader participation of the membership. The disadvantages include the possible selection of directors with no prior experience with the organization or knowledge of how the organization works, dissatisfaction and possible lack of future involvement of unsuccessful candidates and the possible loss of diversity because of the ability of single interest blocks (such as primary specialty or academic background) to use their size to win a majority of slots.

Based on its review the Task Force reached the following conclusions:

- **Currently, the Nominating Committee (Past President, President and President-elect) recommends a slate of candidates for Director positions and Officers to the Board of Directors. The BOD approves the slate and the candidates are submitted to the membership for ratification.**
- **A review of the election practices of 32 other medical organizations found that 44% had contested elections, 41% did not have contested elections, 9% had variable types of elections and 6% did not provide information. All used Nominating Committees to recommend candidates. In the overwhelming majority of cases the Nominating Committee was comprised of Officers/Directors plus members external to the Board of Directors.**

The task force felt that whatever election process is selected should be based on the following principles. Despite the success of the current system, the nominating process would be improved by increasing input from the membership and increasing transparency of the process. The process should insure Directors and Officers with knowledge of, and demonstrated commitment to, the organization. The process should promote diverse representation of the membership on the Board of Directors. Diversity should be maintained with regard to academic background and sleep disciplines. Rather than primary specialties, the diversity of sleep disciplines should be based on broad areas of interest in sleep medicine and sleep science to promote identification of sleep as an independent specialty. These areas of interest include behavioral/psychiatric sleep disorders, childhood sleep disorders and development, movement/neurologic sleep disorders and cardiorespiratory sleep disorders.

The Task Force felt these principles would be best achieved by maintaining the current candidate-slate electoral process but increasing the number and representation on the Nominating Committee. The Task Force recommends that the Nominating Committee be increased from 3 to 5 members with 2 members elected at-large by the membership. In this manner, the Nominating Committee will have input from current and past members of the Board who are familiar with the operations and requirements of the organization as well as input from the general membership. The Nominating Committee will be able to assure diversity on the Board and broad representation of the membership.

Based on its review of models of society election procedures the Task Force makes the following recommendations:

- **Despite the positive outcome of the current system, the Task Force felt the nominating process would be improved by adding external members to the Nominating Committee in order to increase input from the membership and increase transparency of the process.**
- **The Nominating Committee should be composed of five individuals to include: the President, Past President, Past Past President and two AASM members-at-large.**
- **The Nominating Committee will make recommendations on both Officers (President-elect and Secretary-Treasurer) and new Directors.**
- **The two AASM members-at-large will be elected by the membership of the AASM and will each serve a two-year term.**

- o **Self-nomination for these positions will be permitted.**
- o **The terms of the at-large members will run from the June SLEEP meeting to the next SLEEP meeting, the same as for the Board of Directors.**
- o **Terms will be staggered, with one at-large member elected each year.**
- o **The election of at-large members will occur at the same time as the election for the Board of Directors and Officers.**
- o **If no single member has > 50%, then the at-large member will be determined by a runoff election of the top 5 vote getters and the winner decided by plurality.**
- The eligibility requirements to serve as an at-large member are as follows:
  - o At least 5 years membership in the AASM
  - o The nominee must have either served on an AASM Committee or is an active member of an AASM Section.
  - o The at-large member must meet the same conflict of interest standards as required of the AASM Board of Directors.
- The Nominating Committee should continue to promote diverse representation of the membership. The Committee should seek to restore and maintain a more even balance of academic (research and clinician educator) and clinical directors and a balance of sleep disciplines. The sleep disciplines should be based on broad areas of interest (behavioral/psychiatric sleep disorders, childhood sleep disorders and development, movement/neurologic sleep disorders, cardiorespiratory sleep disorders) rather than primary specialties.
- The election should continue to be a candidate-slate election process.
- The task force recommends that the Board of Directors reevaluate the effect of these changes in 5-10 years.

### *Conflict of Interest Policy*

The Board of Directors is entrusted with the responsibility for making clinical, financial, political, regulatory and value judgments for the organization and its membership. The AASM's practice guidelines have a major effect on clinical practice. The organization's advocacy efforts affect the direction of the field of Sleep Medicine. The educational courses and research support shape new practitioners scientists and influence clinical patient care. It is essential that these decisions be evidence-based and not unduly influenced by relationships that pose a conflict of interest or compromise scientific integrity.

In 1997 the AASM Board of Directors put in place a conflict of interest (COI) policy to minimize the influence of industry support on the decisions of the Board, the Executive leadership, Committee members and Task Force members. This policy has been revised and strengthened several times, most recently in 2008 (see appendix 6). The COI policy defines levels of conflict and requirements for each of the leadership levels. The Board of Directors is held to the highest standard. Each Director must complete a yearly COI form identifying any potential conflicts. If a conflict exists, the Director is given the opportunity to resolve the conflict prior to the start of their term. If the Director does not or cannot resolve the conflict, they may not serve on the Board.

Concern regarding COI is surfacing throughout the healthcare industry. The pharmaceutical industry is imposing voluntary limits on sponsorships and gifts and at least one state (Massachusetts) has imposed legislative limits on physician-drug company interactions. A recent article from healthcare leaders (Rothman et al. JAMA 2009;301:1367-72) has called for standards for professional medical associations to prevent the appearance or reality of undue industry influence. This group has particularly called for the leadership of professional medical associations to be held to the highest standards in avoiding conflict of interest.

There is also concern that COI rules can be too restrictive and limit the ability of worthy individuals to serve the AASM. In a period of reduced financial support for research it is often necessary to seek industry funding to conduct important studies. Too strict COI policies would prevent members with desirable skills and insights from serving the organization.

The Task Force reviewed the current COI policy of the AASM and came to the following conclusions:

- The current AASM Conflict of Interest policy is appropriate.
- Potential Directors have the opportunity to resolve potential conflicts if they are interested in serving in a leadership position.

## CONCLUSIONS

The AASM serves many roles, it is an advocacy organization, it is a 20 million-dollar business venture and an event organizer. But at its heart it is a membership organization and must be reflective of the members it represents. Deciding how to fill this role falls to the Board of Directors. The best way to select members to serve on the board is not established, as shown by the diversity of methods used by medical organizations. To date, the task force feels the board has been successful in carrying out its strategic goals and maintaining appropriate diversity that reflects the membership. Whatever method is selected will have its own set of biases. A fully closed nominating process insures selection of a specific mix of Directors but may leave sections of the membership feeling that they are not participants. A fully open nominating process guarantees that anyone interested may participate but will likely favor those who are well known, may exclude those from smaller disciplines within the sleep field and discourage those not successful from participating further. After much discussion and consideration the task force recommends a process that expands the input of the membership but still allows direction to maintain the appropriate diversity.

# APPENDICES

## **APPENDIX 1. ORGANIZATIONS MANAGED BY THE AASM**

AMERICAN ACADEMY OF DENTAL SLEEP MEDICINE

AMERICAN ASSOCIATION OF SLEEP TECHNOLOGISTS

AMERICAN BOARD OF SLEEP MEDICINE

AMERICAN SLEEP MEDICINE FOUNDATION

ASSOCIATED PROFESSIONAL SLEEP SOCIETIES

COMMITTEE ON ACCREDITATION OF EDUCATION FOR POLYSOMNOGRAPHIC TECHNOLOGISTS

SLEEP RESEARCH SOCIETY

SLEEP RESEARCH SOCIETY FOUNDATION

## APPENDIX 2. AASM STRATEGIC PLAN

### Strategic Goals:

1. Sleep Medicine will be widely recognized as an independent medical specialty.
2. AASM will be the leading organization setting standards and meeting professional and patient needs in Sleep Medicine.
3. AASM will be the primary advocate of health policy and health economic issues important to Sleep Medicine.
4. AASM will be the pre-eminent resource for professional and public education in Sleep Medicine.
5. AASM will be the leading advocate for research in Sleep Medicine.
6. AASM will be the most effective and efficient organization in meeting the needs of its members and the profession.



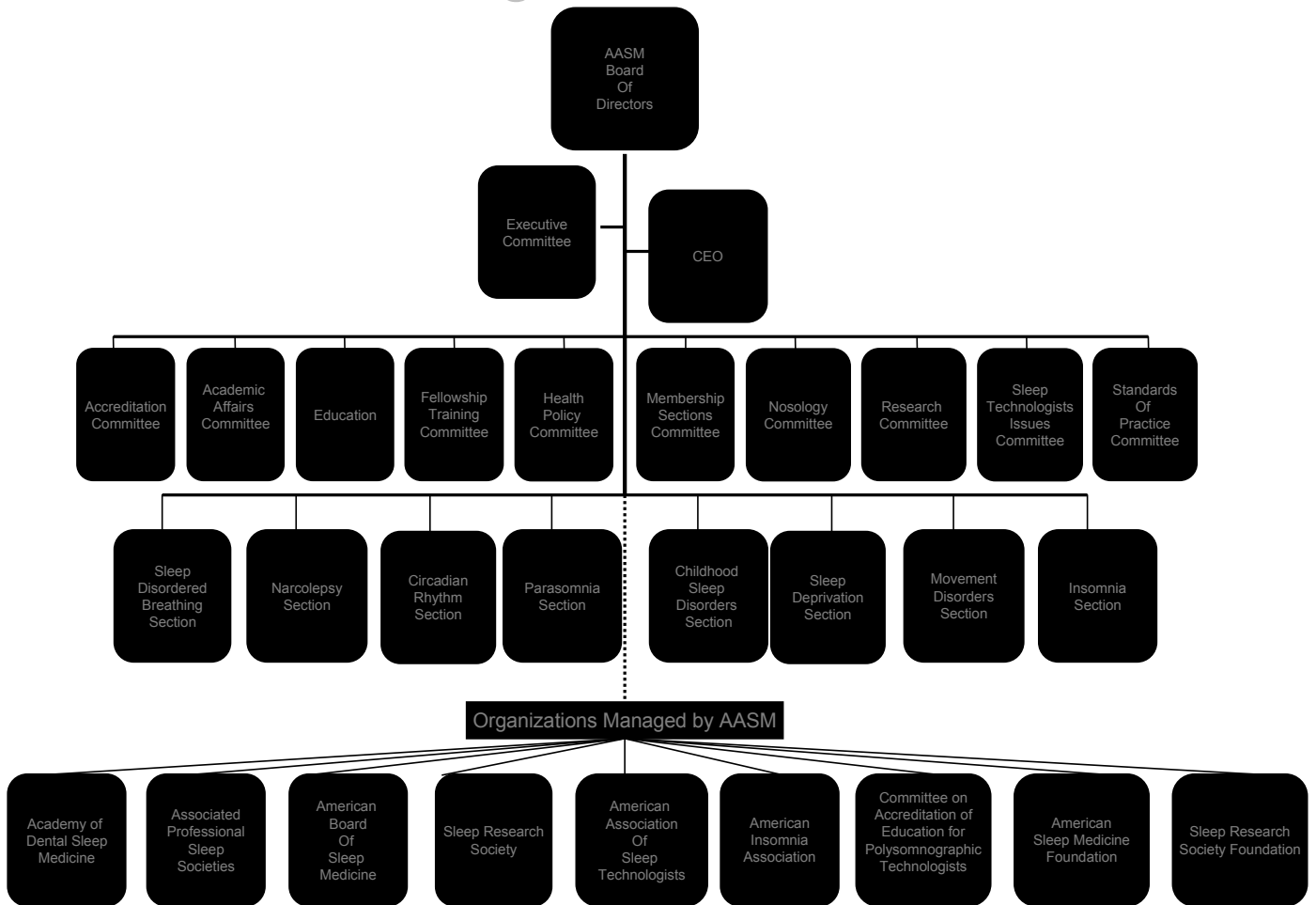
## APPENDIX 3. AASM MEMBERSHIP SURVEY

Out of 1,065 sent, 254 surveys have been returned. Below are the results.

	Very Important	Important	Neutral	Unimportant	Very Unimportant	Left Blank
<b>PRIMARY STRATEGIC GOAL</b> Strategic Goal: Sleep medicine will be widely recognized as an independent medical specialty.	157	62	16	6	7	6
<b>CLINICAL CARE</b> Strategic Goal: AASM will be the leading organization that sets standards and meets professional needs in sleep medicine so that patients are most effectively diagnosed and treated.	169	58	6	1	1	19
• AASM will set standards for new technology and integrate that technology into the practice of sleep medicine.	137	93	19	2	1	2
• AASM will develop best practices and standards of care for sleep problems of all types.	163	73	10	2	2	4
• AASM will demonstrate the effectiveness of sleep medicine specialists.	140	79	21	5	3	6
• AASM will promote the professional diversity of its members and ensure the clinical relevancy of its services.	106	94	37	9	3	5
<b>EDUCATION</b> Strategic Goal: AASM will be the primary resource for professional education in sleep medicine.	111	97	32	5	1	8
• AASM will encourage the acquisition of the necessary knowledge, skills and attitudes for members, colleagues and trainees to be successful professionals in sleep medicine.	127	106	15	3	1	2
• AASM will provide resources to strengthen the medical school curriculum in sleep.	108	115	25	3	1	2
• AASM will develop and promote new academic models for the sleep medicine specialty.	73	110	56	8	3	4
• AASM will promote the development of new sleep medicine fellowship training programs with the goal of increasing sleep medicine fellowships to 50 by 2004.	70	111	55	11	5	2
<b>RESEARCH</b> Strategic Goal: AASM will be the leading advocate for research in sleep medicine.	117	95	26	3	1	12
• AASM will develop innovative methods for attracting new investigators to the sleep science area.	79	129	37	3	2	4
• AASM will increase support for young investigators to collect pilot data in support of further clinical research.	75	132	37	5	2	3
• AASM will increase information to its members about the availability of research funding.	75	119	51	5	2	2
<b>ADVOCACY</b> Strategic Goal: AASM will be a proactive advocate of health policy and health economic issues in sleep medicine.	185	51	9	N/A	1	8
• AASM will increase advocacy efforts to ensure that all sleep related disorders are recognized, diagnosed and treated and reasonably reimbursed.	192	45	8	N/A	1	8
<b>OPERATIONS</b> Strategic Goal: AASM will be the most effective and efficient sleep medicine organization in meeting the needs of its members.	141	82	16	N/A	1	14
• AASM will develop an identifiable and meaningful role for its members with specific interests.	100	111	32	3	1	7

**APPENDIX 4. AASM ORGANIZATIONAL STRUCTURE.**

# AASM Organizational Structure



## APPENDIX 5. SURVEY OF AMA MEMBER ORGANIZATIONS' ELECTION PROCESSES

Organization	# Members	# Board Members	Nominating Committee	Contested Election	Comments
American Academy of Hospice & Palliative Medicine	3,598	17	External; The AAHPM Nominating Committee is chaired by the Immediate Past President and includes the President, President-Elect, and two (2) members at large that have not served on the Board of Directors previously. These at large members are elected by the membership.	Normally yes; this year, no	3 directors-at-large slated for every 2 open positions
American Association of Neuromuscular & Electrodiagnostic Medicine	NP	11	External; The Nominating Committee shall consist of five members: the Past President, the Past Past President and three elected at-large members. The Past President shall be appointed to the committee for 2 years and shall serve as chair of the committee during the second year of his/her term (Past Past President year). The elected at-large members will serve for 3-year terms—one elected each year. Candidates should have experience in administrative matters of the AANEM, and no member shall serve two consecutive terms.	Yes	
American Association of Plastic Surgeons	750	12	External; The Nominating Committee shall consist of a Chair who shall be the immediate Past President of the Association and four additional members, two of whom shall be appointed by the Board at its Annual Meeting, and two of whom shall be elected by the membership from the floor at the Annual Business Meeting.	depends on nominations from nom cmte	
American College of Chest Physicians	NP	NP	External; Consists of 13 members: -ACCP's President two years prior to the in-person meeting of the nominating committee, serving as chair -ACCP's immediate Past President, serving as Vice Chair -two Regents elected by the Board of Regents -two Governors elected by the Council of Governors -two members elected by the Council of NetWorks -two members from the International Council of Regents and Governors, appointed by that council -two Fellows-at-large appointed by the President -one representative from the Past Presidents' Advisory Committee, appointed by that committee	NP	
American College of Occupational and Environmental Medicine	5,000	20	External; We have two nominating committees—one entirely from our House of Delegates that selects members to run for the Board (8 candidates for 4 slots); and a second comprised equally of House and Board members that selects two members to run for Vice President and Secretary-Treasurer (bi-annually).	Yes	
American College of Surgeons	NP	NP	External; Nominating Committee Board of Governors: The members of this committee are nominated by the Executive Committee of the Board of Governors. Nominating Committee of the Fellows: This committee is selected jointly by the ACS President, the Chair of the Board of Regents, and the Chair of the Board of Governors.	No	
American Gastroenterological Association	17,000	12	External; Chair: AGA Past Chair, 4 elected members and 4 appointed members.	No	
American Academy of Facial Plastic and Reconstructive Surgery	3,000	20	External; The Nominating Committee shall consist of 12 fellows, five of whom shall be the regional directors, six of whom shall be elected, and the 12th being the immediate past president of the Academy, who shall serve as committee chairman.	Yes	

Organization	# Members	# Board Members	Nominating Committee	Contested Election	Comments
<b>American Academy of Child &amp; Adolescent Psychiatry</b>	8,000	16	External; The Nominating Committee shall consist of six Fellow and/or Active Members elected by the eligible members in a mail ballot. The Council shall nominate three Fellow and/or Active Members for each position on the Nominating Committee. The President shall appoint one of the six members of the Nominating Committee to serve as Chairperson. The Nominating Committee members shall serve a term of three years.	Yes	
<b>American Academy of Dermatology</b>	16,735	6	External; The Nominating Committee shall consist of six (6) members and a Chair, all seven (7) of whom shall be voting members of the Committee and Fellows of the Academy (or Life or Honorary Members who have been Fellows) in good standing from geographically diverse and representative regions. Members of the Nominating Committee shall serve two consecutive election cycles with staggered terms.	Yes	
<b>American Academy of Family Physicians</b>	94,000	18	N/A; The AAFP does not have a nominating committee. We do have a representative Congress of Delegates (two members from each chapter - 55 chapters overall) which elects members to our Board as well as our national officers. Our chapters nominate individuals for such elections (nominees usually coming from experienced members of the CoD or from our national commissions) annually.	Yes	
<b>American Academy of Ophthalmology</b>	7,000	8	External; The Nominating Committee shall be composed of: (a) the Past President of the Academy serving on the Board of Trustees, as Chair; (b) the two (2) most senior Trustees-at-Large not serving the last year of their term and who are not serving on the Executive Committee; (c) two (2) Senior Secretaries and the Secretary serving on the Board of Trustees who have not served on the previous year's Nominating Committee; (d) one (1) Councilor from each Council Section who is not serving on the Board of Trustees and who is appointed to the Nominating Committee by the affirmative vote of at least a majority of the total number of Councilors of the Council Section, except that if the Academy has more than two (2) Council Sections, the Board of Trustees shall determine by rotation one (1) Councilor from each of only two (2) Council Sections to serve on the Nominating Committee, provided that no Council Section shall be represented for more than two (2) consecutive years; and (e) the Executive Vice President, who shall be a non-voting member of the Committee.	No	

Organization	# Members	# Board Members	Nominating Committee	Contested Election	Comments
<b>American Academy of Pediatrics</b>	60,000	13	External; The American Academy of Pediatrics (AAP) has an elected National Nominating Committee (NNC). The NNC is comprised of 10 members, 1 from each of the 10 geographic AAP districts. Each member is elected by his/her geographic district. Candidates for the NNC are generally identified from members who have been actively involved in their state chapter and/or at the district level, or in other capacities within the AAP, and who have the desire to serve in this capacity. The districts generally will run two candidates for the position of Nominating Committee representative, although on rare occasions, only one candidate is on the ballot. They are precluded from running more than two candidates. The NNC members each serve a term of 3 years and are not eligible for re-election. The primary responsibility of the NNC is to select the two best candidates to run for President-elect of the AAP and to oversee the national AAP election.	Yes	46,000 of 60,000 are voting members
<b>American Association of Clinical Endocrinologists</b>	6,169	36	External; The Committee is comprised of our Immediate Past President (who serves as the chair), five (5) members appointed by the Board of Directors at the summer Board meeting (three of the five must have served for three or more years on the Board), and two (2) members selected by a meeting of AACE Chapter Chairs at the AACE Annual Meeting (usually held in April or May). Also, the AACE President Elect serves as an Ex-Officio (nonvoting) member of the Committee. Members appointed to the Nominating Committee are ineligible for nomination for any Officer or Board position during their scheduled term of service on the Committee.	No	
<b>American Association of Neurological Surgeons</b>	7,585	15	External; Composed of 7 members: Past President (chair), President-elect, and 5 Active Members who are not Directors. The five non-Director members shall be nominated and elected for staggered two-year terms.	No	
<b>American College of Radiology</b>	33,000	12	External; Our College Nominating Committee (CNC) is comprised of 9 members. Three members are elected each year from a slate of at least 5 candidates who compete in a contested election. They serve for one 2-year term renewable if they meet the qualification of being a councilor or alternate councilor. The other three committee members include 2 from the Board of Chancellors (BOC) appointed by the chair of the BOC each serving a one 2-year term (staggered) and one from the Council Steering Committee (CSC) appointed each year by the speaker of the Council.	Yes	20,000 of members are active
<b>American College of Rheumatology</b>	8,000	19	External; Immediate Past-President is the Chair, ACR President, ACR President-Elect, REF (our affiliated foundation) Vice-President, Practice Representative, Research Representative, Education Representative, ARHP (our health professional division) Representative, two at-large members.	No	
<b>American Medical Group Association</b>	92,000	13-17	External; Three senior Board officers and three non-Board members selected to provide "outside" and geographic balance to the selection process.	No	
<b>American Orthopedics Association</b>	1,500	19	External; The Nominating Committee shall consist of the immediate Past-President, who shall serve as the Nominating Committee Chair, and four members elected by the Membership at or immediately after the Executive Session of the Annual Meeting.	Yes	

Organization	# Members	# Board Members	Nominating Committee	Contested Election	Comments
<b>American Society for Clinical Pathology</b>	120,000	19	External; consists of the Immediate Past President, who serves as Chair, three Fellows, three Members, and one Resident	No	
<b>American Society of Bariatric Surgeons</b>	1,300	11	External; The Nominating Committee shall be composed of the President-Elect, who shall serve as the chairperson of the Nominating Committee; and four Society members who are appointed by the Board of Trustees.	No	
<b>American Society of Cytopathology</b>	3,100	18	External; The Nominating Committee consists of three (3) Medical Members and one (2) Cytotechnologist members. The committee consists of is appointed by the President-Elect prior to assuming the office of President and subject to the approval of the Executive Board. The President-Elect shall designate one (1) member to be Chair of the Nominating Committee. (It is suggested that the Committee composition consist of the three most recent past presidents and two most recent past Executive Board Cytotechnologists members.)	Yes	1,500 members can vote
<b>American Academy of Orthopedic Surgeons</b>	35,256	17	External; 6 members are elected by the membership	Yes	
<b>American Association for Thoracic Surgery</b>	NP	12	External; The Nomination Committee shall consist of the five (5) immediate Past Presidents of the Association. The most senior Past President shall serve as Chair. This Committee shall prepare a slate of nominees for Officers and Councilors upon instruction from the Council as to the vacancies which are to be filled by election.	NP	
<b>American Society of Addiction Medicine</b>	3,100	21	External; a) The Nominations and Awards Council shall be composed of the Immediate Past President as Chair (who shall vote only in the event of a tie); the President (with vote); the President-Elect (ex officio, without vote); two (2) ASAM council/committee chairpersons, elected by all ASAM council/committee chairpersons; two (2) chapter presidents elected by all chapter presidents; two (2) members of the Board of Directors elected by the Board; and the Executive Vice President (ex officio, without vote). The terms of appointment will be concurrent with the term of the President.	Yes	
<b>American Society for Therapeutic Radiology and Oncology</b>	10,000	13	External; The Nominating Committee shall consist of eleven (11) members. The Chair of the Nominating Committee shall be the Immediate Past Chair of the Board of Directors. The four (4) Council Chairs shall be members. The other six (6) members of the Committee shall be members of the Society who are not then serving on the Board of Directors. These six (6) members shall be elected to two-year terms.	Yes	
<b>American Urological Association</b>	16,362	13	External; AUA is comprised of 8 autonomous geographical sections, each with their own nominating committee.	Determined by the sections, which appoint the nominees	
<b>Congress of Neurological Surgeons</b>	6,342	12	External; • Seven members o Past, Past President: Chair o Past President o Five members appointed from the membership at large (two year terms)	No	

<b>Organization</b>	<b># Members</b>	<b># Board Members</b>	<b>Nominating Committee</b>	<b>Contested Election</b>	<b>Comments</b>
<b>Infectious Diseases Society of America</b>	NP	18	External; Has six members and chair. Immediate Past President serves as chair and then goes on to serve an additional 3 year term. The four most recent past presidents are on the committee. The other three members are usually chosen from more senior members who have been active in the Society. All serve a three year term. Terms are staggered so two members rotate off each year.	No	
<b>Renal Physicians Association</b>	NP	15	External; A Nominating Committee shall be selected by the Board of Directors on or before July 1 of each year. The Nominating Committee shall have at least three members. The Nominating Committee shall be composed of representatives of the Board of Directors and the membership-at-large and one member of the Nominating Committee shall at all times be a Counselor.	No	
<b>SNM Advancing Molecular Imaging &amp; Therapy</b>	16,000	18 (13 voting; 5 nonvoting)	External; The six (6) Nominating committee members will be elected by voting members of the House of Delegates, nominated from the voting members of the House of Delegates. The following positions will be elected: Three (3) Chapter Delegates Two (2) Council Delegates One (1) Technologist Section Delegate	Yes	
<b>Society for Vascular Surgery</b>	2,800	23	External; The Nominating Committee shall consist of five (5) members. The two (2) most recent surviving and available Past-Presidents, the more senior of whom shall serve as Chair of the committee. One (1) member elected annually from and by the eleven (11) representatives of the regional and national vascular societies serving on the Board of Directors. One (1) member elected annually by the five (5) representatives of the Councils seated on the Board of Directors. One (1) member at large elected from the Society membership and who is not serving currently on the Board of the Directors or on one of the councils of the Society.	No	

NP=Information not provided

## APPENDIX 6. AASM CONFLICT OF INTEREST POLICY

### REVISED, October 2008 AASM Conflict of Interest Policy

#### A. Conflict of Interest (COI) Committee Mandate

The COI Committee is elected by the Board of Directors from among its members. It will consist of three members (including the chair) and an alternate who will function in the case of conflict of interest of one of the three members. Members are appointed for a term of one year with an option of re-appointment for a further 2 years.

The AASM Board of Directors Conflict of Interest (COI) Committee is charged by the Board to:

1. Establish COI policies for the AASM.
2. Determine when conflicts of interest arise, determine when they are satisfactorily resolved, and report high level conflicts to the Board.

#### B. Levels of Conflict of Interest

1. *Level 1* – Persons with a current level 1 conflict of interest cannot hold the position in question unless the conflict is resolved.
2. *Level 2* – Persons with a current level 2 conflict of interest can hold the position in question but must both disclose the conflict and recuse themselves from AASM activities related to the specific conflict.
3. *Level 3* – Persons with a current level 3 conflict of interest can hold the position in question but must disclose the conflict.

#### C. Conflict of Interest Criteria

**1. Board of Directors.** The BOD is held to the highest conflict of interest standard, as members have ultimate responsibility for all activities of the AASM and have the highest public visibility as representatives of the Academy.

##### *a. Level 1*

- 1) Membership in paid or unpaid industry/corporate (for profit) boards of directors or advisory boards related to sleep.
- 2) Direct ownership or ownership by a spouse or children of either more than 5% of a company selling sleep products or services or stock in such a company of value  $\geq$ \$25,000. (The ownership of sleep centers by practicing sleep physicians is excluded)
- 3) Employment by manufacturers of sleep related diagnostic or therapeutic devices or medications, defined as 50% or more of total yearly non-investment income derived from such a commercial entity.
- 4) Acceptance of payments for speaking engagements from industry, except from an unrestricted educational grant or an ACCME accredited program.
- 5) Membership in an industry speaker's bureau.
- 6) Recipient of a personal gift (value  $>$ \$500) provided by a sleep related business.



*b. Level 2*

- 1) Recipient of a research or travel grant from a commercial entity.
- 2) Recipient of a personal gift of value \$250-\$500 provided by a sleep related business.
- 3) Discounted or free use of material or equipment of value  $\geq$ \$250 provided by a sleep related business
- 4) Direct ownership or ownership by a spouse or children of stock in an individual company selling sleep products or services of greater than \$10,000 but less than \$25,000. (The ownership of sleep centers by practicing sleep physicians is excluded)
- 5) Ownership by the individual or a spouse or children of a vendor of sleep related durable medical equipment. (The dispensing of durable medical equipment by sleep centers and laboratories is excluded).

*c. Level 3*

- 1) Recipient of a research or travel grant from a governmental or not for profit entity.
- 2) Service on the Board of Directors or Medical Advisory Board of another professional organization.

**2. Senior AASM Staff.**

The Executive Director and Assistant Executive Directors of the Academy are held to the same COI standards as the Board of Directors.

**3. Chairs of the Standards of Practice Committee, Clinical Practice Committee and Health Policy Committee and CME Committee**

The chairs of these committees are held to the same COI standards as the Board of Directors

**4. Chair and Members of the Accreditation Committee and Site Visitors.**

*a. Level 1.*

- 1) Partial or sole ownership or membership of the Board of Directors or Advisory Board (paid or unpaid) of a corporate entity that has as one of its goals the establishment of multiple sleep laboratories or sleep disorders centers.
- 2) Partial or sole ownership or membership of the Board of Directors or Advisory Board (paid or unpaid) of a corporate entity that has as one of its goals the provision of services or consultations to aid in the establishment or accreditation of sleep laboratories or centers.

*b. Level 2.*

Ownership or participation in any capacity in the activities of a sleep disorders center or sleep laboratory. *(It is understood that almost all members of the Accreditation Committee and site visitors will have such a conflict. The purpose of specifying it is to ensure that they will recuse themselves from any accreditation activities that could be perceived to be in competition with their own entity.)*

*c. Level 3*

- 1) Membership in paid or unpaid industry/corporate (for profit) boards of directors or advisory boards related to sleep.
- 2) Employment by manufacturers of sleep related diagnostic or therapeutic devices or medications, defined as 50% or more of total yearly non-investment income derived from such a commercial entity.
- 3) Direct ownership or ownership by a spouse or children of either more than 5% of a company selling sleep products or services or stock in such a company of value greater than \$25,000.
- 4) Acceptance of payments for speaking engagements from industry, except from an unrestricted educational grant or an ACCME accredited program.
- 5) Membership in an industry speaker's bureau.
- 6) Recipient of a research or travel grant from a commercial entity.
- 7) Recipient of a personal gift, discounted or free use of material or equipment of value >\$250 provided by a sleep related business.

**5. Members of the Standards of Practice Committee and Health Policy Committee**

*a. Level 1*

None

*b. Level 2*

- 1) Membership in paid or unpaid industry/corporate (for profit) boards of directors or advisory boards related to sleep.
- 2) Direct ownership or ownership by a spouse or children of either more than 5% of a company selling sleep products or services or stock in such a company of value greater than \$25,000. (The ownership of sleep centers by practicing sleep physicians is excluded)
- 3) Employment by manufacturers of sleep related diagnostic or therapeutic devices or medications, defined as 50% or more of total yearly non-investment income derived from such a commercial entity.
- 4) Acceptance of payments for speaking engagements from industry, except from an unrestricted educational grant or an ACCME accredited program.
- 5) Membership in an industry speaker's bureau.
- 6) Recipient of a research or travel grant from a commercial entity.
- 7) Recipient of a personal gift, discounted or free use of material or equipment of value >\$250 provided by a sleep related business.

*c. Level 3*

- 1) Recipient of a research or travel grant from a governmental or not for profit entity.
- 2) Service on the Board of Directors or Medical Advisory Board of another professional organization.
- 3) Direct ownership or ownership by a spouse or children of stock in an individual company selling sleep products or services of greater than \$10,000 but less than \$25,000. (The ownership of sleep centers by practicing sleep physicians is excluded)

## **6. Task Force Chairs and Standards of Practice Committee Liaisons to Task Forces**

### *a. Level 1*

- 1) Membership in paid or unpaid industry/corporate (for profit) board of directors or advisory board related to the topic of the task force.
- 2) Direct ownership or ownership by a spouse or children of either more than 5% of a company selling sleep products or services related to the topic of the task force or stock in such a company of value greater than \$25,000.
- 3) Employment by manufacturers of sleep related diagnostic or therapeutic devices or medications with a link to the topic of the task force., defined as 50% or more of total yearly non-investment income derived from such a commercial entity.
- 4) Acceptance of payments for speaking engagements from industry with a link to the topic of the task force, except from an unrestricted educational grant or an ACCME accredited program.
- 5) Membership in an industry speaker's bureau with a link to the topic of the task force,
- 6) Recipient of a personal gift, discounted or free use of material or equipment of value  $\geq$ \$250 provided by a business with a link to the topic of the task force.

### *b. Level 2*

None

### *c. Level 3*

- 1) Recipient of a research or travel grant from a commercial entity with a link to the topic of the task force.
- 2) Direct ownership or ownership by a spouse or children of stock of greater than \$10,000 but less than \$25,000 related to the topic of the task force.
- 3) Recipient of a personal gift of value \$50-\$250 provided by a sleep related business with a link to the topic of the task force.
- 4) Discounted or free use of material or equipment of value  $\geq$ \$250 provided by a sleep related business with a link to the topic of the task force.

## **7. Chairs and Members of all other AASM Committees, Course Directors and Task Force Members**

### *a. Level 1*

None

### *b. Level 2*

None

### *c. Level 3*

- 1) Membership in paid or unpaid industry/corporate (for profit) boards of directors or advisory boards related to sleep.
- 2) Direct ownership or ownership by a spouse or children of either more than 5% of a company selling sleep products or services or stock in such a company of value greater than \$25,000. (The ownership of sleep centers by practicing sleep physicians is excluded)
- 3) Acceptance of payments for speaking engagements from industry, except from an unrestricted educational grant or an ACCME accredited program.
- 4) Membership in an industry speaker's bureau.
- 5) Recipient of a research or travel grant from a commercial entity.
- 6) Recipient of a personal gift, discounted or free use of material or equipment of value  $>$ \$250 provided by a sleep related business.

#### **D. Procedure for the COI Committee**

1. New nominees to the BOD and AASM Committees identified by the Nominating Committee and the Committee on Committees are asked to complete COI forms. All current BOD and committee members must also complete a yearly COI form in March each year. The executive director and assistant executive directors must complete COI forms by January 31st of each year and submit these to the COI committee.
2. These forms are reviewed by the staff and all levels 1 and 2 conflicts of interest with respect to new nominees are referred to the COI Committee. Any changes in COI of existing members are also referred.
3. The committee meets prior to the April BOD Meeting (conference call or e-mail discussion) to review these conflicts.
4. The committee reports conflicts to the BOD at the April Meeting. Nominees or existing board or committee members are informed about the policy regarding levels 1 and 2 conflicts. Committee chairs are notified about level 2 conflicts of their members.
5. For level 1 conflicts, the replies of the persons involved are referred back to the COI Committee to assess whether the conflicts have been resolved. The committee reports back to the board.
6. Should a change of circumstances occur during the course of the year, committee and board members must promptly complete a new COI form which will be reviewed by staff and referred if necessary to the COI Committee for review.
7. A similar process will apply if a new task force is set up in the course of the year.
8. All COI forms will be retained in the AASM office but will not be placed on the web site. However, they will be released on written request by a member of the Academy or the public.

#### **E. Failure of COI Disclosure**

1. The Board of Directors shall have the right to take whatever steps it deems necessary against any person who is required to submit a COI form but fails to disclose a current level 1 or 2 COI. These shall include, but not be limited to, removal from office and banning that person from holding any further office in the AASM for a specified or unlimited time. The same shall apply to persons with level 2 COI who do not recuse themselves as required by these rules.
2. Failure to submit a timely COI form may result in removal from office at the discretion of the BOD.