AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
888.626.9262
osteopathic.org

SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
EDUCATIONAL AFFAIRS - RESOLUTION ROSTER
WITH ACTION

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:

- Committee on Educational Affairs (200 series)
  This reference committee reviews and considers matters relating to osteopathic education, osteopathic colleges, and postdoctoral training.

Res. No.	Resolution Title	Submitted By	Action
H200	Graduate Medical Education – Training of US Medical School Graduates (H213-A/15)	BOE	ADOPTED
H201	Rural Sites – Osteopathic Education in (H214-A/15)	BOE	ADOPTED
H202	Directors of Medical Education Overseeing Osteopathic Postdoctoral Training Programs (H216-A/15)	BOE	ADOPTED as AMENDED
H203	Autopsies (H217-A/15)	BOE	ADOPTED
H204	Clarity Regarding Matching Service Listing of AOA Residencies with ACGME Pre-Accreditation Status (H219-A/15)	BOE	ADOPTED *(for sunset)*
H205	Blue Ribbon Commission Report (H223-A/15)	BOE	ADOPTED
H206	AOA to Support Education and Advocate for Policies Relating to Climate Change	MOA	NOT ADOPTED
H207	Adoption of Specific Informed Consent Guideline for Sensitive Exams Under Anesthesia for Education Purposes	SOMA	REFERRED
H208	Incorporating Continuing Medical Education Opportunities on Human Trafficking	SOMA	REFERRED
H209	Incorporating Continued Medical Education Regarding Intellectual and Developmental Disabilities	SOMA	ADOPTED as AMENDED
H210	Recommendation of Buprenorphine Waiver Training in Osteopathic Medical Schools	BSAPH	NOT ADOPTED
H211	Referred Res. No H-224 – A/2019 AOA Board Certification Terminology	BOS	NOT ADOPTED
H212	Residency Redistribution of Center for Medicare/Medicaid Services Funding Following Single Accreditation Systems (SAS)	OPSC	NOT ADOPTED
H213	Training High Quality Physicians in a Healthy and Safe Environment	MAOP	NOT ADOPTED
H214	Audition Rotations for Osteopathic Medical Students	IOMA	ADOPTED as AMENDED

SUBJECT: H213-A/15 GRADUATE MEDICAL EDUCATION – TRAINING OF US MEDICAL SCHOOL GRADUATES

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H213-A/15 GRADUATE MEDICAL EDUCATION – TRAINING OF US MEDICAL SCHOOL GRADUATES

The American Osteopathic Association advocates for the elimination of limitations on the number of funded graduate medical education positions to accommodate increases in US medical school enrollment; places great emphasis on establishing graduate medical education opportunities for osteopathic medical school graduates in geographic areas that lack adequate training capacity and as needed to meet future workforce needs. 2009; referred 2014; approved as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H214-A/15 RURAL SITES – OSTEOPATHIC EDUCATION IN

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H214-A/15 RURAL SITES – OSTEOPATHIC EDUCATION IN

The American Osteopathic Association encourages clinical rotations in rural settings by osteopathic medical students and graduates during their respective predoctoral and postdoctoral education programs. 1990; revised 1995, 2000, 2005, 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H216-A/15 DIRECTORS OF MEDICAL EDUCATION OVERSEEING OSTEOPATHIC POSTDOCTORAL TRAINING PROGRAMS

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

RESOLVED, that the Bureau of Osteopathic Education recommends ~~that~~ the following policy be ~~SUNSET~~ **REAFFIRMED as AMENDED**.

(Old language is crossed out and new language is in CAPS)

H216-A/15 ~~DIRECTORS OF~~ MEDICAL ~~EDUCATION OVERSEEING OSTEOPATHIC~~ POSTDOCTORAL TRAINING PROGRAMS

The American Osteopathic Association will ~~continue the present requirement that the Director of Medical Education overseeing osteopathic postdoctoral training programs must be an osteopathic physician~~ **ENCOURAGE~~ENSURE~~** THE CONTINUED TEACHING OF OSTEOPATHIC PRINCIPLES AND PRACTICES **THROUGH BUT NOT LIMITED TO OSTEOPATHIC RECOGNITION** IN GRADUATE MEDICAL EDUCATION PROGRAMS AND ENCOURAGES OSTEOPATHIC PHYSICIANS TO SEEK FACULTY AND ADMINISTRATIVE POSITIONS IN GRADUATE MEDICAL EDUCATION PROGRAMS. 2010, reaffirmed 2015.

Explanatory Statement: Submitted by Author

The BOE recommends this policy be sunset because Directors of Medical Education are not required by the ACGME.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H217-A/15 AUTOPSIES

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H217-A/15 AUTOPSIES
The American Osteopathic Association encourages medical schools, private hospital systems and public medical facilities to allow the viewing of autopsies by medical students and residents for teaching purposes. 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H219-A/15 CLARITY REGARDING MATCHING SERVICE LISTING OF AOA RESIDENCIES WITH ACGME PRE-ACCREDITATION STATUS

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be SUNSET.

(Old language is crossed out and new language is in CAPS)

H219-A/15 CLARITY REGARDING MATCHING SERVICE LISTING OF AOA RESIDENCIES WITH ACGME PRE-ACCREDITATION STATUS

The American Osteopathic Association (AOA) will provide guidance to the osteopathic student body regarding the timelines of residency program transition between the NRMP and NMS matching services. The AOA will openly distribute information regarding the match transition and its implications to osteopathic medical students applying to those residency programs, starting in the period leading up to the pre-accreditation eligibility of AOA residency programs. 2015

Explanatory Statement: Submitted by Author
The BOE recommends this policy be sunset because the AOA no longer offers a separate AOA Match.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED *(for sunset)***

DATE: **October 14, 2020**

SUBJECT: H223-A/15 BLUE RIBBON COMMISSION REPORT

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H223-A/15 BLUE RIBBON COMMISSION REPORT
The American Osteopathic Association (AOA) encourages colleges of osteopathic medicine to collaborate with appropriate regulatory authorities, licensing boards, certifying boards, the National Board of Osteopathic Medical Examiners, and other stakeholders in their pursuit of innovative pilot studies to produce primary care, competency-based physician team leaders and the AOA will monitor the outcomes of these pilot programs and the route to board certification. 2015

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: HOD Reference Committee
The Committee heard singular testimony advocating sunset due to perceived lack of action, while others felt there remains ongoing value in the collaboration embodied in the resolution. The resolution directs the AOA to monitor the Blue Ribbon Commission pilot studies and the Committee respectfully recommends a summary report be provided by the AOA as an informational item for the 2021 House of Delegates.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: AOA TO SUPPORT EDUCATION AND ADVOCATE FOR POLICIES RELATING TO CLIMATE CHANGE

SUBMITTED BY: Maine Osteopathic Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, there is agreement within the scientific community that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant; and

WHEREAS, these climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the economically disadvantaged; and

WHEREAS, the American Osteopathic Association (AOA) has encouraged efforts to promote standards which will prevent human suffering and death from environmental threats and hazards; and supported efforts to eradicate environmentally related health risks since 1970; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports educating the medical community on the potential adverse public health effects of global climate change; and, be it further

RESOLVED, that AOA encourages American Association of Colleges of Osteopathic Medicine (AACOM) to advocate for their member osteopathic medical schools to incorporate the health implications of climate change into their curricula, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies and, be it further

RESOLVED, that AOA advocates for and support epidemiological, translational, clinical and basic science research, in order that global climate change policy decisions related to health care and treatment have an appropriate evidence base and, be it further

RESOLVED, that AOA encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

Explanatory Statement: Submitted by Author

Resolved 3 refers to H402-A/18 ENVIRONMENTAL HEALTH. Passed in 1970; revised 1978; reaffirmed 1983; revised 1988; reaffirmed 1993; revised 1998, 2003; reaffirmed 2008; reaffirmed 2013; 2018.

Explanatory Statement: Reference Committee

The Committee heard testimony mostly against the resolution. Advocates commented that environmental health is a public health issue. The Committee believes that the current policy, H402-A/18 demonstrates the AOA's commitment to Environmental Health. In H402-A/18, the AOA strongly encourages the federal government to increase its efforts to promote standards which will

prevent human suffering and death from environmental threats and hazards; and reaffirms its commitment to support governmental agencies' efforts in eradicating environmentally related health risks. Regarding this resolution's call for incorporating health implications of climate change into osteopathic medical school curricula, the Committee believes that osteopathic medical schools should have the autonomy to choose their curricula based on the COCA requirements, their curriculum committee, and their mission statement, and that this was beyond the scope and authority of the AOA.

Background Information: Provided by AOA Staff
Current AOA Policy: H402-A/18 ENVIRONMENTAL HEALTH

Prior HOD action on similar or same topic: Policy reaffirmed in 2018.

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: ADOPTION OF SPECIFIC INFORMED CONSENT GUIDELINE FOR SENSITIVE EXAMS UNDER ANESTHESIA FOR EDUCATION PURPOSES

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, patient consent is critical to patient care; and

WHEREAS, physicians, residents, and medical students have a duty to respect the autonomy of patients; and

WHEREAS, sensitive exams are defined as pelvic exams, rectal exam, clinical breast exam, urogenital exams[1]; and

WHEREAS, the performance of sensitive exams under general anesthesia without specific informed consent can lead to severe psychological stress for the patient, damage to the patient provider relationship, and a distressing experience for the medical student or resident[2]; and

WHEREAS, thirty-nine states have no law explicitly banning the practice of performing pelvic exams on general anesthetized patients without their specific consent[3]; and

WHEREAS, in a study conducted in 2003, 90% of students surveyed had completed a pelvic exam on general anesthetized patient who had not given informed consent[4]; and

WHEREAS, If asked for specific consent prior to surgery, 62% of women claimed they would consent to a medical student performing a pelvic exam while under general anesthesia for educational purposes, showing that asking does not significantly impact learning opportunities[5]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) adopt guidelines that require the practicing physician or resident to obtain specific informed consent before the resident or medical student performs a sensitive exam for education purposes on a patient who is under general anesthesia.

Explanatory Statement: Submitted by Author

Performing sensitive exams on unconscious patients for educational purposes is not a new practice[5]. Public awareness in the 1990's saw the introduction of limited state legislation against the practice[2]. Today there are 11 states that have banned the performance of sensitive exams under anesthesia without specific consent[3]; Wisconsin and Florida have proposed bills under consideration[6,7]. It is difficult to predict the number of educational pelvic exams under anesthesia without specific consent being performed today but recent lawsuits as well as reports from patients and medical students indicate the practice is still occurring nationally[2,3,6,7].

References

1. University Health Service. (n.d.). *University of Michigan*. Retrieved February 21, 2020, from https://www.uhs.umich.edu/sensitive-exams
2. Friesen, P. Educational pelvic exams on anesthetized women: Why consent matters. *Bioethics*. 2018; 32: 298– 307. https://doi.org/10.1111/bioe.12441
3. Goldberg, E. (2020, February 17). She Didn't Want a Pelvic Exam. She Received One Anyway. *New York Times*. Retrieved February 21, 2020, from https://www.nytimes.com/2020/02/17/health/pelvic-medical-exam-unconscious.html
4. Ubel, Peter A, et al. (February 2003). Don't ask, don't tell: A change in medical student attitudes after obstetrics/gynecology clerkships toward seeking consent for pelvic examinations on an anesthetized patient. *American Journal of Obstetrics & Gynecology*, Volume 188, Issue 2, 575 – 579
5. Cundall, H., MacPhedran, S., & Arora, K. (2019, December). Consent for Pelvic Examinations Under Anesthesia by Medical...: *Obstetrics & Gynecology*. Retrieved February 21,2020, fromhttps://journals.lww.com/greenjournal/Fulltext/2019/12000/Consent_for_Pelvic_Examinations_Under_Anesthesia.23.aspx?casa_token=oPri3J4ogx8AAAAA:k-v1Z0A8izkAtAX3vcyWc_0MTL7uUDLFIPKzbSVUxGlVULCEd7SQcmEtOi4bM48xh-nbgFr312d8Yk6VhtT9z5X_
6. Wahlberg, D., & Wisconsin State Journal. (2020, January 7). Bill seeks informed consent for pelvic exams under anesthesia by medical students. Retrieved February 20, 2020, from https://madison.com/wsj/news/local/health-med-fit/bill-seeks-informed-consent-forpelvic-exams-under-anesthesia-by/article_ab30b282-0507-5c0f-93c5-83143f74ae86.html
7. Press, T. A. (2020, February 19). Florida bill would require consent to perform pelvic exams. Retrieved February 21, 2020, from https://www.wfla.com/news/florida/florida-bill-would-require-consent-to-perform-pelvic-es/

Explanatory Statement: Reference Committee

The Committee respectfully recommends this resolution be referred back to its authors, the Student Osteopathic Medical Association (SOMA). The Committee was supportive of the resolution's intent but felt that current policy, H223-A/19, is broad enough to include the encounters such as that referred to in the resolution. The Committee recommends that the SOMA study current AOA policy H223-A/19 and consider resubmitting a resolution for a future HOD that amends H223-A/19, should the SOMA believe there is a need to include specific informed consent for sensitive exams under anesthesia in the current AOA policy. In addition, the Committee also recommends the authors consider defining sensitive exams in a Resolved statement so that its definition will be included in the AOA policy compendium.

Background Information: Provided by AOA Staff

Current AOA Policy: H223-A/19 EDUCATION OF STUDENTS AND FACULTY ON OBTAINING PERMISSION BEFORE ALL STUDENT AND PATIENT ENCOUNTERS

Prior HOD action on similar or same topic: Policy approved in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Student Osteopathic Medical Association)*

DATE: **October 14, 2020**

SUBJECT: ~~**INCORPORATING**~~ **ENCOURAGING** CONTINUING MEDICAL EDUCATION OPPORTUNITIES ON HUMAN TRAFFICKING

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, human trafficking is defined as ~~**the use of force, fraud, or coercion to obtain some type of labor or commercial sex act**~~ **COMPLEX CRIME INVOLVING THE EXPLOITATION OF SOMEONE FOR THE PURPOSES OF COMPELLED LABOR OR A COMMERCIAL SEX ACT, THROUGH THE USE OF FORCE, FRAUD, OR COERCION. WHEN A PERSON UNDER 18 IS USED TO PERFORM A COMMERCIAL SEX ACT, IT IS HUMAN TRAFFICKING WHETHER OR NOT THERE IS ANY FORCE, FRAUD, OR COERCION**[1]; and

WHEREAS, an estimated 40.3 million people are victims of human trafficking globally, 4.8 million of which are in forced sexual exploitation for profits of an estimated $99 Billion US dollars per year[2]; and

WHEREAS, 1 million children are victims of sex trafficking globally[3]; and

~~**WHEREAS, 14,500 to 17,500 people are trafficked into the United States each year[4]; and**~~

WHEREAS, 1 in 6 reported runaways in the United States are presumed to be victims of child sex trafficking[5]; and

WHEREAS, trafficking victims experience higher rates of the following healthcare concerns: STI's, pregnancy, unsafe abortion, malnourishment, illness from unsanitary conditions, and physical and mental abuse manifestations such as PTSD and depression[6]; and

WHEREAS, studies have shown that 28-88% of trafficking victims have come into contact with the healthcare system while being trafficked [6, 7]; and

WHEREAS, the American College of Osteopathic Emergency Physicians reports that only 10% of physicians recognize human trafficking victims and 3% of emergency physicians receive training on human trafficking[8]; and

WHEREAS, only three medical schools in the United States have formal case based simulation training in identifying victims of human trafficking during the first three years of medical education, none of which are osteopathic medical schools[9,10]; and

WHEREAS, "Educating healthcare professionals on the topic cannot be limited to one subspecialty as trafficking victims have a wide variety of physical symptoms… To reach the widest range of subspecialties, education must occur during undergraduate medical education and focus on practical aspects of providing care for trafficked persons as well as identifying elements of trafficking"[10]; and

WHEREAS, a multitude of organizations, including the World Health Organization, have released statements regarding the need for awareness of the signs of human trafficking in healthcare professionals[8,11,12,13]; and

WHEREAS, it is recommended that medical school and emergency medicine residency curricula should include training in recognizing and intervening for patients surviving human trafficking[8]; and

WHEREAS, American Osteopathic Association policy H401-A/14 Human Trafficking—Awareness as a Global Health Problem acknowledges human trafficking as a global public health problem and encourages awareness among osteopathic physicians[14]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) ~~**incorporate**~~ **ENCOURAGE** continuing medical education opportunities on recognizing the signs and risk factors of human trafficking.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

References

1. Human trafficking definition: Department of Homeland Security. (2019, June 28). What Is Human Trafficking? Retrieved from http://www.dhs.gov/blue-campaign/what-human-trafficking
2. Worldwide Human trafficking prevalance: International Labor Organization. (2017, September 19). Forced labour, modern slavery and human trafficking. Retrieved from https://www.ilo.org/global/topics/forced-labour/lang--en/index.h
3. Global Estimates of Modern Slavery: Forced Labour and Forced Marriage. (2017, September 19). Retrieved February 25, 2020, from https://www.ilo.org/global/publications/books/WCMS_575479/lang--en/index.htm
4. Clawson, H. J., Dutch, N., Solomon, A., & Goldblatt Grace, L. Human trafficking into and within the United States: a review of the literature 1–54 (n.d.). Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/report/human-trafficking-and-within-united-states-review-literature#Trafficking
5. National Center for Missing and Exploited Children. (n.d.). About NCMEC. Retrieved February 10, 2020, from http://www.missingkids.org/footer/media/keyfacts
6. Sy, E., Pusey, J. O., Cho, N., Marin, L., Dagdagan, M., Whiteman, R., … Marigold, J. A. (2005). Turning pain into power: Trafficking survivors' perspectives on early intervention strategies. [Booklet]. San Francisco, CA: Family Violence Prevention Fund.
7. Lederer, L. J., & Wetzel, C. A. (2014). The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities.
8. Reyes, J. (2019, July 24). Confronting Human Trafficking. Retrieved from American College of Osteopathic Emergency Physicians: https://acoep.org/main/publications/patientswithautism-4/
9. University of Louisville. UofL, Harvard and USF provide model for medical schools to teach the signs of human trafficking. Retrieved February 17, 2020, from https://louisville.edu/medicine/departments/pediatrics/news/uofl-harvard-and-usf-provide-model-for-medical-schools-to-teach-the-signs-of-human-trafficking

10. Hanni Stoklosa, Michelle Lyman, Carrie Bohnert & Olivia Mittel (2017) Medical education and human trafficking: using simulation, Medical Education Online, 22:1, 1412746, DOI: 10.1080/10872981.2017.1412746
11. Human Trafficking. (2016, October 4). Retrieved February 25, 2020, from https://www.aafp.org/about/policies/all/human-trafficking.html
12. Human Trafficking. (n.d.). Retrieved February 25, 2020, from https://www.acep.org/patient-care/policy-statements/human-trafficking/
13. Human trafficking. (2014, November 28). Retrieved February 25, 2020, from https://www.who.int/reproductivehealth/publications/violence/rhr12_42/en/
14. HUMAN TRAFFICKING – AWARENESS AS A GLOBAL HEALTH PROBLEM. (2019). Retrieved February 17, 2020, from https://osteopathic.org/about/leadership/policy-search/?aoatextsearchinline=trafficking
15. INCLUSION OF HUMAN TRAFFICKING TRAINING IN OSTEOPATHIC MEDICAL SCHOOL CURRICULA. (2017, March 4). Retrieved February 17, 2020, from https://studentdo.org/soma-policy-database/?aoatextsearchinline=traffickin

Explanatory Statement: Reference Committee

The Committee recommends amendments to correct terminology and statistics and to reduce the perceived fiscal impact on the AOA as well as encourage all CME sponsors to consider providing educational offerings on this topic. Further, the Committee was informed that a number of State licensing boards already include this topic among those required.

Background Information: Provided by AOA Staff

Current AOA Policy: H401-A/19 HUMAN TRAFFICKING – AWARENESS AS A GLOBAL HEALTH PROBLEM

Prior HOD action on similar or same topic: Policy reaffirmed in 2019.

FISCAL IMPACT: Up to approximately $130,000 in additional expense.

The amount of additional expense will depend upon the type of activity and number of CME hours involved. For example, a conservative estimate based upon a one CME hour journal article would be $13,000, whereas, a high-end estimate based upon a 10 credit CME in-person workshop could be $130,000.

ACTION TAKEN: **REFERRED** *(to Bureau of Osteopathic Education with proposed amendments)*

DATE: **October 14, 2020**

SUBJECT: ~~**INCORPORATING**~~ **ENCOURAGING** CONTINUED MEDICAL EDUCATION REGARDING INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, "developmental disabilities" are defined as a group of lifelong conditions due to an impairment in physical, learning, language, behavioral areas, or self-care before the age of 22[1]; and

WHEREAS, people with disabilities make up the largest legally protected group in the country since the passage of the ADA in 1990[1]; and

WHEREAS, over a billion people live with a disability, including 54 million Americans according to the World Report on Disability[2]; and

WHEREAS, the life expectancy of people with intellectual disabilities has increased by 200% over the past 80 years, while the life expectancy of the general population has increased by approximately 30%[3]; and

WHEREAS, for the first time in the course of human history, there are now more adults living with intellectual and developmental disabilities (I/DD) than children[3]; and

WHEREAS, it has been shown that people with disabilities report seeking more healthcare than people without disabilities and have greater unmet needs[4]; and

WHEREAS, Patients with intellectual disabilities also encounter additional challenges in accessing healthcare compared to the general population[4]; and

WHEREAS, health promotion and preventative medical care rarely target people with disabilities; examples range from a lower rate of cervical and breast screenings for patients to unmonitored weight for patients with I/DD compared to patients without I/DD[4]; and

WHEREAS, communication barriers and complexity of social/medical situations for this particular population were the main reasons clinicians felt like they were not able to deliver adequate care[5]; and

WHEREAS, barriers to receiving healthcare are not only physical, but also perhaps more importantly related to the knowledge and attitudes of healthcare providers[5] ; and

WHEREAS, people with disabilities have cited negative attitudes and behaviors of healthcare providers as the most formidable barriers to accessing healthcare services[5]; and

WHEREAS, medical students, residents, and practicing physicians have demonstrated deficiencies in the most basic patient care towards common forms of disability, such as cerebral palsy and learning disabilities[5] ; and

WHEREAS, given the range in exposure to clinical populations, there is no guarantee that medical students will interact with patients with disabilities in medical school[6]; and

WHEREAS, providers have reported feeling inadequate in addressing this population's healthcare needs due to lack of education received in prior years of schooling,[4] and illnesses that are readily apparent in persons without disabilities may remain undiagnosed in individuals with I/DD[5]; and

WHEREAS, 40% of internal medicine physicians do not feel comfortable caring for patients with chronic disease of childhood-onset secondary to lack of familiarity with the literature, lack of training with this population, and lack of coordination among specialists[8]; and

WHEREAS, Section 5307 of the Patient Protection and Affordable Care Act states that a model disability curriculum should be developed that addresses "cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities";[2] however, only a few healthcare programs have included disability topics within their curriculum[2]; and

WHEREAS, a multitude of medical schools have incorporated education tools within their curriculum to improve medical students' preparedness for communicating with persons with disabilities that led students to report feeling more prepared and knowledgeable about properly caring for this community[6]; and

WHEREAS, a study of pre-clinical medical school curriculum focused on healthcare disparities of and biases towards disabled communities in an effort to change the current attitudes of healthcare providers towards persons with disabilities led to the majority of medical students involved in this curriculum development course responding positively and believing community involvement with patients would be helpful for future clinical work[2]; and

WHEREAS, results from physician education seminars for a clinical improvement program in the treatment of the intellectual and developmental disabilities population reveal statistically significant improvements in self-assessed competence and clinician knowledge[9]; and

WHEREAS, in order to improve the quality of healthcare for people with I/DD, individual providers must expand their knowledge base and skill set via professional education to be integrated with didactic and clinical training that include: direct interactions with these patients, history taking, cultural practices, diagnostic treatment, as well as counseling and supporting individuals[7]; and

WHEREAS, AOA sponsored conferences since January 1, 2019 did not discuss specific topics regarding the care and treatment of the adult intellectual and developmental disabilities population[9]; and

WHEREAS, AOA Resolution H211-A/18 "encourages osteopathic medical schools to develop and implement curricula on the care of people with developmental disabilities[10]"; and

WHEREAS, by instilling earlier education into the medical curriculum, along with continuing education for all levels of practice, improvements may be seen in the degree of comfort and quality of care that is delivered[10]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) ~~**incorporates**~~ **ENCOURAGES CONTINUING MEDICAL EDUCATION OPPORTUNITIES** ~~**content**~~ regarding intellectual and developmental disability care for adults~~ **during AOA-sponsored conferences**~~.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

References

1. Davis, L.J. (2015). Enabling acts: the hidden story of how the Americans with Disabilities Act gave the largest U.S. minority its rights. Boston: Beacon Press.
2. Rogers J.M., Morris M.A., Hook C.C., Havyer R.D. Introduction to disability and health for preclinical medical students: didactic and disability panel discussion. MedEdPORTAL. 2016;12:10429. https://doi.org/10.15766/mep_2374-8265.10429
3. Curriculum-NCIDM. (n.d.). Retrieved February 2, 2020, from https://aadmd.org/page/ncidmpreamble 4. Who.int. (2020). Disability and health. Retrieved February 1, 2020, from https://www.who.int/newsroom/fact-sheets/detail/disability-and-health
4. Symons, A. B., McGuigan, D., & Akl, E. A. (2009). A curriculum to teach medical students to care for people with disabilities: development and initial implementation. BMC medical education, 9, 78. https://doi.org/10.1186/1472-6920-9-787
5. Minihan, P. M., Bradshaw, Y. S., Long, L. M., Altman, W., et al. (2004). Teaching about disability: involving patients with disabilities as medical educators. Disability Studies Quarterly, 24(4). doi: 10.18061/dsq.v24i4.883
6. Office of the Surgeon General (US); National Institute of Child Health and Human Development (US); Centers for Disease Control and Prevention (US). (2002). Closing the gap: a national blueprint to improve the health of persons with mental retardation: report of the surgeon general's conference on health disparities and mental retardation. Washington (DC): US Department of Health and Human Services. Goals and Action Steps. Retrieved January 10, 2020, from https://www.ncbi.nlm.nih.gov/books/NBK44354/
7. Douthitt Stief, H., & Clark, M. (2013, December 29). A survey of patients, families and providers about care of patients with intellectual disabilities. Retrieved February 2, 2020, from http://aadmd.org/articles/survey-patients-families-and-providers-about-care-patients-intellectualdisabilities
8. Social model of disability. (2017, April 12). Retrieved February 14, 2020, from https://www.mentalhealth.org.uk/learning-disabilities/a-to-z/s/social-model disability
9. American Osteopathic Association Events. (2019). https://osteopathic.org/about/aoa-events/
10. American Osteopathic Association 98th Annual House of Delegates Meeting. (2018). http://policysearch.wpengine.com/wp-content/uploads/H211-A2018-

DEVELOPMENTAL-DISABILITIES-CURRICULUM-ON-THE-CARE-OF-PEOPLE.pdf

Explanatory Statement: Reference Committee
The Committee heard mixed testimony on this resolution. Advocates wished to highlight the topic of disability through inclusion during AOA conferences. Those in opposition cited the potential fiscal note. The Committee believes the AOA House of Delegates should not mandate specific CME content at AOA-sponsored conferences. Decisions on CME content should be based on the CME sponsor's practice gap analysis of its intended audience, which may include sessions regarding the care of disabled patients.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: Up to approximately $130,000 in additional expense.
The amount of additional expense will depend upon the type of activity and number of CME hours involved. For example, a conservative estimate based upon a one CME hour journal article would be $13,000, whereas, a high-end estimate based upon a 10 credit CME in-person workshop could be $130,000.

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: RECOMMENDATION OF BUPRENORPHINE WAIVER TRAINING IN OSTEOPATHIC MEDICAL SCHOOLS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Educational Affairs

WHEREAS, opioid overdose has become a leading cause of death in the United States[1]; and

WHEREAS medication-assisted treatment (MAT), including buprenorphine formulations and other opioid receptor agonists and antagonists, is an effective, evidence-based treatment for opioid use disorder (OUD) and is an integral part of guidelines promoted by the National Institute on Drug Abuse and the American Society of Addiction Medicine[2]; and

WHEREAS the Drug Addiction Treatment Act of 2000 (DATA 2000) requires prescribers to undergo a training regimen designed by the US Drug Enforcement Agency (DEA) before receiving authorization to prescribe MAT[3]; and

WHEREAS the American Osteopathic Association and its member institutions are committed to fully equipping osteopathic medical students with the evidence-based tools needed to meet the most pressing needs of 21st century medicine[4]; now, therefore be it

RESOLVED, the American Osteopathic Association recommends that osteopathic medical schools will adopt and incorporate an approved DATA 2000 waiver training program into their core curricula, with implementation no later than the matriculating class of 2022.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

References

1. Lawrence Scholl et al., "Drug and Opioid-Involved Overdose Deaths — United States, 2013–2017," *MMWR. Morbidity and Mortality Weekly Report* 67, no. 5152 (January 4, 2018): 1419–27, https://doi.org/10.15585/mmwr.mm675152e1.
2. National Institute on Drug Abuse, "Principles of Effective Treatment," accessed May 28, 2020, https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment; Sandra Comer et al., "National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use," 2015, 66; Roger D. Weiss et al., "Long-Term Outcomes from the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study," *Drug and Alcohol Dependence* 150 (May 1, 2015): 112–19, https://doi.org/10.1016/j.drugalcdep.2015.02.030.
3. Substance Abuse and Mental Health Services Administration, "MAT Statutes, Regulations, and Guidelines," accessed May 28, 2020, https://www.samhsa.gov/.

4. Stephen C. Shannon, "Reevaluating Osteopathic Medical Education for the 21st Century and Beyond," *The Journal of the American Osteopathic Association* 114, no. 4 (April 1, 2014): 228–30, https://doi.org/10.7556/jaoa.2014.046.

Explanatory Statement: Reference Committee

The Committee believes the policy as written is inappropriate because the AOA lacks sufficient authority over educational curricula, as that rests with the COCA. Curricular initiatives addressing the treatment of pain and opioid use disorder already currently exist at many osteopathic medical schools. In addition, the Committee believes that waiver training in osteopathic medical school may be too early since osteopathic medical students do not have DEA certificates and would be more appropriate training during residency, temporally closer to the time when they would prescribe medications for opioid use disorder.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: REFERRED RES. NO H-224 – A/2019 AOA BOARD CERTIFICATION TERMINOLOGY

SUBMITTED BY: Bureau of Osteopathic Specialists

REFERRED TO: Committee on Educational Affairs

RESOLVED, THAT THE TERMINOLOGY FOR AMERICAN OSTEOPATHIC ASSOCIATION ISSUED BOARD CERTIFICATIONS SHOULD STATE THAT A CERTIFICATE HOLDER IS "BOARD CERTIFIED IN THE PRINCIPLES AND PRACTICE OF OSTEOPATHIC "SPECIALTY"

Explanatory Statement: Submitted by Author:
The BOS believes that adding Osteopathic in front of the specialty name is redundant and unnecessary. The certification is an osteopathic certification because it comes from the American Osteopathic Association, and therefore, the inclusion of Osteopathic Principles and Practices is strongly implied. There is no doubt that the certification is osteopathic as the word osteopathic appears on each certificate a minimum of five (5) times.

Explanatory Statement: Reference Committee
At the 2019 House of Delegates, the House referred Resolution H224-A/19 to the Bureau of Osteopathic Specialists (BOS) for review and recommendation. Resolution H211, submitted by BOS, does not respond to the 2019 House of Delegates request, and therefore, Resolution H224-A/19 still requires final action by the House of Delegates. The Committee presents Substitution Resolution H211, which is the resolved statement from H224-A/19. The testimony heard by the Committee was in opposition to this language, and generally supportive of the current terminology included on AOA board certificates. The Committee supports the BOS and its member certifying boards, believing that the BOS and its member certifying boards must have the authority to determine the terminology used on AOA board certificates. Current AOA board certificates state the word, "Osteopathic" a minimum of five (5) times and the Committee believes this to be sufficient.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: AOA BOARD CERTIFICATION TERMINOLOGY

SUBMITTED BY: Massachusetts Osteopathic Society

REFERRED TO: Committee on Educational Affairs

WHEREAS, the mission statement of the American Osteopathic Association (AOA) is to "advance the distinctive philosophy and practice of osteopathic medicine"; and

WHEREAS, the mission statement of the Bureau of Osteopathic Specialties (BOS) states that "the BOS is the certifying body for the approved specialty boards of the AOA and is dedicated to establishing the high standards for certification of osteopathic physicians"; and

WHEREAS, the AOA advertises the DO difference on www.doctorsthatdo.org, by stating that "There are more than 100,000 DOs in the US, practicing their distinct philosophy in every medical specialty. We have additional training in OMT and use this tool to help diagnose, treat and prevent illness and injury"; and

WHEREAS, www.doctorsthatdo.org also claims that "by combining the latest advances in medical technology with OMT, Doctors of Osteopathic Medicine offer their patients the most comprehensive care available in medicine today"; and

WHEREAS, osteopathic medical schools provide 4 years of distinct training in Osteopathic Principles and Practice (OPP) and OMT via minimal standards established by ECOP, including over 200 hours of training in OMT, with practical exams, OSCE, and COMLEX exams"; and

WHEREAS, the results of a survey of 214 people, 96% of whom were practicing DOs across the USA, shows that 88% of respondents agree that osteopathic certification terminology should clearly state a holder is certified in osteopathic principles and practice; and

WHEREAS, Appendix A of the July 2018 BOS Handbook has approved terminology for certification already approved that states, "General certification represents a distinct and well defined field of osteopathic medical practice; now, therefore be it

RESOLVED, that the terminology for American Osteopathic Association issued board certifications should state that a certificate holder is "Board certified in the Principles and Practice of Osteopathic "Specialty".

Reference Committee Explanatory Statement:

Specific terminology on certificates is determined by the BOS and the individual certifying boards. The Committee requests the BOS report back to the 2020 House of Delegates on this issue.

ACTION TAKEN **REFERRED** *(to Bureau of Specialists)*

DATE **July 27, 2019**

ACTION TAKEN: **NOT ADOPTED by action of substitute resolution H211 – Oct. 13 2020**

DATE: **October 14, 2020**

SUBJECT: RESIDENCY REDISTRIBUTION OF CENTER FOR MEDICARE/MEDICAID SERVICES FUNDING FOLLOWING SINGLE ACCREDITATION SYSTEMS (SAS)

SUBMITTED BY: Osteopathic Physicians & Surgeons of California

REFERRED TO: Committee on Educational Affairs

WHEREAS, the Accreditation Council of Graduate Medical Education (ACGME) ratified the Memorandum of Understanding (MOU) for the Single Accreditation Systems (SAS) with the American Osteopathic Association (AOA) and American Association of Colleges of Osteopathic Medicine (AACOM) in 2014 for the transition of AOA accredited residencies into ACGME accredited programs starting in 2015; and

WHEREAS, the majority of Graduate Medical Education (GME) residency funding is by Centers of Medicare Medicaid Services (CMS) through direct graduate medical education (DGME) funding and indirect funding (IME); and

WHEREAS, the vast majority of those AOA accredited residencies that applied under SAS successfully achieved ACGME accreditation but without an increase in the total CMS funded GME residency positions; and

WHEREAS, a percentage of AOA accredited programs did not apply for ACGME accreditation and will close after the July 2020 date with a loss of CMS funded GME positions during a time when more funded ACGME positions are needed; and

WHEREAS, the consequence of many the AOA accredited programs not applying for transition from AOA accreditation to ACGME accreditation will be the loss of CMS funded positions and will significantly affect those communities that had GME positions prior to July 1, 2020 and are in need for medical care; and

WHEREAS, CMS may redistribute some or all the GME funded but closed residency training positions to other ACGME residencies; now therefore be it

RESOLVED, that the American Osteopathic Association (AOA) advocate and work in conjunction with the Accreditation Council of Graduate Medical Education (ACGME) to advocate for the continued development and Centers of Medicare Medicaid Services (CMS) funding of ACGME accredited residency training programs in rural and underserved areas affected by Graduate Medical Education (GME) residency position losses; and, be it further

RESOLVED, that the AOA advocates that CMS prioritizes funding new residency positions, and that these funds are not used to offset non-CMS funded residency positions.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee

The Committee received testimony that was mostly against the adoption of this resolution, including a desire by the authors to withdraw the resolution. The Committee believes that the current policies, H213-A/15, H329-A/16, and H201-A/19 satisfactorily address the concepts proposed within this resolution.

Background Information: Provided by AOA Staff

Current AOA Policy:

H329-A/16 GRADUATE MEDICAL EDUCATION FUNDING AND INCENTIVES
H201-A/19 GRADUATE MEDICAL EDUCATION – INCREASING OPPORTUNITIES

Prior HOD action on similar or same topic: H320-A/16 policy approved in 2016; H201-A/19 reaffirmed in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: TRAINING HIGH QUALITY PHYSICIANS IN A HEALTHY AND SAFE ENVIRONMENT

SUBMITTED BY: Maryland Association of Osteopathic Physicians

REFERRED TO: Committee on Educational Affairs

WHEREAS, the goal of osteopathic medical schools is to train competent, caring physicians who will be comfortable caring for people in all clinical care settings, and

WHEREAS, all osteopathic medical schools have developed their own method of assessment designed to assure that students acquire and demonstrate core clinical skills, and

WHEREAS, the COVID-19 pandemic has created challenges and risks to students who have to travel to national standardized examinations administered by the National Board of Osteopathic Medical Examiners (NBOME) to one of two standardized testing centers run by the NBOME, and

WHEREAS, the COVID-19 pandemic has created challenges and risks to students by exposing students to standardized patients, and

WHEREAS, the NBOME is still striving to schedule and administer a standardized clinical skills/performance evaluation examination to all current osteopathic medical students in a safe manner, and

WHEREAS, the NBOME has provided conflicting information on scheduling dates for this examination to osteopathic medical students which has necessitated multiple rescheduled examinations, and

WHEREAS, communication from the NBOME on plans to make the performance evaluation/clinical skills exam safe for students and with key stakeholders needs to be done in a timely manner, and

WHEREAS, the time and resources required of students to take the clinical skills/performance evaluation removes students from the learning environment with required travel for longer than other alternatives, and

WHEREAS, all osteopathic medical schools have clinical skills training sites at each college of osteopathic medicine, and

WHEREAS, technology has provided us with new efficient and safe ways to assess the same skills; now therefore be it,

RESOLVED, that the American Osteopathic Association (AOA) work with key stakeholders to provide safe and remote clinical skills testing without granting a monopoly to any one business entity; and be it further

RESOLVED, that clinical skills testing in a standardized, safe and effective format be provided in the safest manner possible even if that means that the tests be provided through the Colleges of Osteopathic Medicine or other entities such as state or specialty societies, and be it further

RESOLVED, that American Association of Colleges of Osteopathic Medicine (AACOM) and the AOA work to create a feedback system for the National Board of Osteopathic Medical Examiners' (NBOME) performance regarding communication with students and key stakeholders, and attention to safety and industry standards in scheduling test administration to see how the NBOME performs and where an increased focus might be necessary to meet the standards expected.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
The Committee heard mixed testimony, but mostly against the adoption of this resolution. The Committee believes that the resolution is not within the AOA's authority. The AOA does not mandate the work of AACOM, NBOME, or Colleges of Osteopathic Medicine. The intent of the resolution is wholly supported, and the Committee is hopeful that the clinical skills testing will be given in a standardized, safe and effective format.

Background Information: Provided by AOA Staff
Current AOA Policy: H206-A/16 COMLEX-USA LEVEL 2-PE

Prior HOD action on similar or same topic: Policy reaffirmed in 2016.

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: AUDITION ROTATIONS FOR OSTEOPATHIC MEDICAL STUDENTS

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, the Single Accreditation System (SAS) was fully implemented on July 1, 2020; and

WHEREAS, most FOURTH-YEAR medical students ~~must~~ CHOOSE TO schedule VISITING STUDENT OR "audition" rotations at ~~hospitals~~ INSTITUTIONS, OTHER THAN THOSE AFFILIATED WITH THEIR OWN MEDICAL SCHOOL ~~which~~ THAT sponsor residencies into which the student desires to match; and

WHEREAS, some ~~hospitals~~ INSTITUTIONS charge FOURTH-YEAR medical students a fee for ~~participating in audition~~ VISITING STUDENT rotations; and

WHEREAS, in some ~~hospitals~~ INSTITUTIONS, FOURTH-YEAR osteopathic medical students are required to pay substantially higher fees than allopathic students ~~are required to pay~~ or are being refused the opportunity to participate in ~~audition~~ VISITING STUDENT rotations solely because they are enrolled in an osteopathic medical college[1]; ~~and~~

~~WHEREAS, this places osteopathic medical students at a significant disadvantage in matching into their desired residency program and causes them to incur significantly higher expenses compared to allopathic medical students;~~ now therefore be it,

RESOLVED, that the American Osteopathic Association (AOA), ~~through its representatives to the Accreditation Council in Graduate Medical Education (ACGME)~~ PARTNER WITH INTERESTED STAKEHOLDERS INCLUDING, BUT NOT LIMITED TO, THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES(AAMC) AND AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE (AACOM) TO ADDRESS ~~seek changes to the institutional accreditation standards to prohibit~~ the discriminatory practice of **PROHIBITING MEDICAL STUDENTS FROM VISITING STUDENT ROTATIONS OR CHARGING DIFFERENT FEES TO MEDICAL STUDENTS BASED SOLEY ON THEIR OSTEOPATHIC TRAINING** ~~charging osteopathic medical students a fee different than~~ FROM THAT ~~is charged to allopathic students for audition~~ VISITING STUDENT ~~rotations (E.G. AUDITION ROTATIONS)~~; and, be it further

RESOLVED, that the AOA WORK WITH ANY AND ALL RELEVANT ORGANIZATIONS TO ~~also~~ seek ~~any other~~ necessary changes in institutional or residency ~~standards~~ **POLICIES AND/OR** PRACTICES **THAT PROHIBIT VISITING STUDENT ROTATIONS OR CHARGE INEQUITABLE FEES TO MEDICAL STUDENTS BASED SOLELY ON THEIR OSTEOPATHIC TRAINING** ~~to prevent any ACGME accredited institution or program from discriminating~~ THAT MAY ALLOW FOR BIAS against osteopathic medical students or residents ~~in any way~~; and, be it further

RESOLVED, that ~~when~~ the AOA WILL CONTINUE TO ADVOCATE FOR OSTEOPATHIC MEDICAL STUDENTS AND RESIDENTS WITH INSTITUTIONS, PROGRAMS, AND OTHER RELEVANT STAKEHOLDERS WHEN THE AOA becomes aware of any instance of discrimination ~~against osteopathic medical students, it shall advocate on behalf of the students with the institution~~.

Explanatory Statement: Submitted by Author

1. See the following example:

"The University of Iowa Carver College of Medicine annually accepts applications from visiting fourth year medical students from LCME accredited schools. (We *cannot* accept applications from D.O. students in Osteopathic programs)"

"Visiting Student Information and Application", *University of Iowa, Carver School of Medicine*, https://medicine.uiowa.edu/md/student-support/visiting-student-information-and-application, accessed June 10, 2020

"A nonrefundable application fee of $150 for MD students is due on receipt of an offer for externship. DO and International medical students are required to pay a nonrefundable fee of $4,150 on receipt of an offer for externship."

"Visiting Students for Academic Year 2020-2021", University of Colorado School of Medicine, http://www.ucdenver.edu/academics/colleges/medicalschool/education/studentaffairs/extern/Pages/default.aspx, accessed June 10, 2020

"2. APPLICATION FEE – NOT REQUIRED FOR LCME-APPROVED OR DOMESTIC MEDICAL SCHOOLS.

Osteopathic Students: $50 payable to "UIC" in the form of a money order, traveler's check or cashier's check.
Fee waived (LCME/domestic)"

"Checklist for non-UIC medical students applying for electives and sub-internships at the university of Illinois college of medicine", *University of Illinois, College of Medicine,* http://chicago.medicine.uic.edu/wp-content/uploads/sites/6/2017/08/Medical-students-Visiting-Complete-packet_032917-1.pdf, accessed June 10, 2020

Explanatory Statement: Reference Committee

The committee heard mixed testimony but general support for the premise of the initial resolution. It was noted that the ACGME does not have purview over medical students or any fees charged to them for visiting, or "audition", rotations. The committee believes that the proposed amended resolution captures the spirit of the initial resolution and addresses the responsible stakeholder organizations.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
888.626.9262
osteopathic.org

SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
PROFESSIONAL AFFAIRS - RESOLUTION ROSTER
WITH ACTION

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:

- Committee on Professional Affairs (300 series)
  This reference committee reviews and considers matters relating to osteopathic health care facilities, advocacy, legislation, membership and conventions.

Res. No.	Resolution Title	Submitted By	Action
H300	Intractable and/or Chronic Pain (Not Associated with End of Life Care) (H327-A/15)	BSGA	REFERRED
H301	Retail-Based Health Clinics and Urgent Care Centers (H303-A/15)	BSAPH	ADOPTED as AMENDED
H302	Protecting American Students from Profit-Driven Foreign Medical Schools (H304-A/15)	BFHP	ADOPTED
H303	Remove FDA Ban on Anonymous Sperm Donation from Men Who Have Sex with Men (H305-A/15)	BFHP / BSAPH	ADOPTED
H304	Improving Competitive Edge for Membership in the AOA (H308-A/15)	BOM	ADOPTED
H305	Tax Credit for Precepting (H312-A/15)	BSGA	ADOPTED as AMENDED
H306	Site Neutral Reimbursement (H396-A/15)	BFHP	ADOPTED as AMENDED
H307	Supporting the Use of OMM in the VA (H311-A/15)	BHFP	ADOPTED
H308	Practice Rights of Osteopathic Physicians (H313-A/15)	BSGA	ADOPTED as AMENDED
H309	Retail Medical Clinics in Facilities Selling Tobacco, Nicotine or Vaping Products (H314-A/15)	BSAPH	ADOPTED as AMENDED
H310	Osteopath and Osteopathy - Use of the Term (H315-A/15)	BIOM	ADOPTED
H311	Patient Access in Rural Areas (H317-A/15)	BSGA	ADOPTED *(for sunset)*
H312	Physician Office Laboratories (H318-A/15)	BFHP	ADOPTED
H313	Postgraduate Compensation (H319A/15)	BOE	ADOPTED as AMENDED
H314	Second Opinion, Surgical Cases (H320-A/15)	BSA	ADOPTED
H315	Uniformed Services: Endorsement of Physicians Serving in the Uniformed Services (H322-A/15)	BFHP	ADOPTED as AMENDED
H316	Emergency Medical Services for Children, Support of (H323-A/15)	BFHP	ADOPTED as AMENDED

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
888.626.9262
osteopathic.org

SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
PROFESSIONAL AFFAIRS - RESOLUTION ROSTER
WITH ACTION

Res. No.	Resolution Title	Submitted By	Action
H317	Physician Incentives to Underserved Areas (H324-A/15)	BSGA	ADOPTED
H318	Vaccines Shortages (H326-A/15)	BFHP	ADOPTED as AMENDED
H319	Medicare Balance Billing (H329-A/15)	BFHP	ADOPTED as AMENDED
H320	Electronic Prescribing of Controlled Substances (H332-A/15)	BSA	ADOPTED *(for sunset)*
H321	Professional Organization -- Physicians Choosing to Which They Belong (H334-A/15)	BOM	NOT ADOPTED
H322	Prescription Drug Diversion and Abuse – Education, Research, and Advocacy (H335-A/15)	BSGA	ADOPTED
H323	Buprenorphine Maintenance Treatment Insurance Coverage (H336-A/15)	BSA	ADOPTED
H324	Violence Against Healthcare Staff (H337-A/15)	BSGA	ADOPTED as AMENDED
H325	Low Back Pain Clinical Practice Guidelines, Revision of (H338-A/15)	BOCER	ADOPTED as AMENDED
H326	Addressing the Effects of Climate on National Health	SOMA	REFERRED
H327	Adverse Childhood Experiences Screening	SOMA	ADOPTED as AMENDED
H328	Inclusion of Patient Education on Organ Donation as a Component of a Primary Care Visit	SOMA	NOT ADOPTED
H329	Inequalities in Medicaid Funding Affecting U.S. Territories	SOMA	ADOPTED as AMENDED
H330	Improving Insulin Affordability	SOMA	REFERRED
H331	Medication for Opioid Use Disorder Insurance Coverage	AOAAM	NOT ADOPTED
H332	Recruitment and Retention of Native Americans in Medicine	SOMA	NOT ADOPTED
H333	WITHDRAWN	SOMA	WITHDRAWN
H334	Sustainability at AOA Events	MOA	NOT ADOPTED
H335	H357-A/19 Nutrition and Leading By Example	OPSC	NOT ADOPTED
H336	REFERRED RESOLUTION: H324-A/14 Use of the Term "Physician" "Doctor" and "Provider"	BSGA	ADOPTED

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
888.626.9262
osteopathic.org

SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
PROFESSIONAL AFFAIRS - RESOLUTION ROSTER
WITH ACTION

Res. No.	Resolution Title	Submitted By	Action
H337	CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016	IOMA	ADOPTED as AMENDED

SUBJECT: H327-A/15 INTRACTABLE AND / OR CHRONIC PAIN (NOT ASSOCIATED WITH END OF LIFE CARE)

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H327-A/15 INTRACTABLE AND/OR CHRONIC PAIN (NOT ASSOCIATED WITH END OF LIFE CARE)

The American Osteopathic Association supports the enactment of legislation concerning the administration of controlled substances to persons experiencing intractable and/or chronic non-malignant pain substantially conforming to the attached definitions and requirements; and will advocate and promote to students, residents, fellows and practicing physicians educational resources regarding addictive disorders, diversion awareness and monitoring and appropriate referral resources, as well as the prevention and treatment of pain disorders.

Definitions:

A. Intractable ~~and/or chronic~~ pain means a pain state in which the cause of the pain cannot be removed or otherwise definitively treated and which in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, a face to face evaluation by the attending physician and one or more physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain. Chronic non-malignant pain may be associated with a long-term incurable or intractable medical condition or disease.

THE CENTERS FOR DISEASE CONTROL AND PREVENTION DEFINES CHRONIC PAIN AS "PAIN THAT TYPICALLY LASTS >3 MONTHS OR PAST THE TIME OF NORMAL TISSUE HEALING. CHRONIC PAIN CAN BE THE RESULT OF AN UNDERLYING MEDICAL DISEASE OR CONDITION, INJURY, MEDICAL TREATMENT, INFLAMMATION, OR AN UNKNOWN CAUSE."[1]

~~Requirement~~GUIDELINES:

A. Notwithstanding any other provision of law, a physician may prescribe or administer controlled substances to a person in the course of the physician's treatment of the person for a diagnosed condition causing intractable and/or chronic pain. This includes patients with chemical dependency and/or substance abuse history if chronic pain exists

[1] Dowell, Deborah; Haegerich, Tamara; Chou, Roger. "CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016." *Recommendations and Reports*, March 18, 2016 / 65(1);1–49. *See* https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm.

and controlled substance management is indicated. Physician hypervigilance in screening for drugs of abuse, as well as the presence of the treatment medication in these patients is necessary.

B. No physician shall be subject to ~~disciplinary~~ ADVERSE action (by the state medical board, EMPLOYERS, INSURERS, ETC.) for appropriately prescribing or administering controlled substances in the course of treatment of a person for intractable pain and/or chronic pain.

C. No physician shall be subject to criminal prosecution (by state or federal agencies) for appropriately prescribing or administering medically necessary controlled substances in the course of treatment of a person for intractable pain and/or chronic pain.

D. This section shall not authorize a physician to prescribe or administer controlled substances to a person the physician knows to be using drugs or substances for non-therapeutic purposes.

E. This section ~~does not affect~~ IS NOT INTENDED TO INTERFERE WITH the power (of the state medical board) to deny, revoke, or suspend the license of any physician who fails to keep accurate records of purchases and disposal of controlled substances, writes false or fictitious prescriptions for controlled substances, or prescribes, administers, or dispenses in violation of state controlled substances actS.

~~Recent court decisions in multiple states have criminalized civil malpractice litigation. This has resulted in subsequent incarceration and/or other imposed criminal sentencing. Therefore, the previously adopted AOA language supporting appropriate, medically necessary pain management needs to be revisited. Furthermore, the term intractable pain is ambiguous as to the source. A policy on hospice related pain exists and is supportive of palliative care, including opiate and/or controlled substance management for terminally ill patients. This defines intractable pain in the terminally ill, but further clarification is necessary for chronic pain. Chronic pain might also necessitate opiate and/or controlled substance management for patients when other interventions have been inadequate. Opiate and/or controlled substance management in treating chronic pain patients in those with substance abuse disease issues is now supported as a standard of care by the medical literature. Such patients require physician hypervigilance as part of this standard of care.~~ (2005, revised 2010)

Explanatory Statement: Submitted by Author

The final paragraph was deleted because according to Suffolk University's *Journal of Health & Biomedical Law*, "only about 15 appellate cases of criminal medical malpractice" occurred between 1809 and 1981, and there have only been a handful of criminal cases since. This data does not support the statements that "[r]ecent court decisions in multiple states have criminalized civil malpractice litigation. This has resulted in subsequent incarceration and/or other imposed criminal sentencing. Therefore, the previously adopted AOA language supporting appropriate, medical necessary pain management needs to be revisited."

H438-A/17 END OF LIFE CARE – POLICY STATEMENT ON is the current AOA policy referenced in lines 28-29 on page 2. This policy is supportive of palliative care and physicians' ability to prescribe appropriate analgesics for pain without fear of repercussions, but it does not define "intractable pain" or specifically mention opioids; therefore, those lines have been deleted.

Explanatory Statement: Reference Committee
It is unclear if this is to be a guideline as suggested by the change from "Requirement" to "Guidelines" in page 1, line 27, or if it is to be model legislation as suggested by the language in section B or C of the "Guidelines". Recommend language be clarified to be consistent with model legislation since there is a lack of evidence-based literature referenced. Also recommend title of resolution be updated to match language change proposed on page 1, line 13.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Council on State Health Affairs)*

DATE: **October 14, 2020**

SUBJECT: H303-A/15 RETAIL-BASED HEALTH CLINICS AND URGENT CARE CENTERS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H303-A/15 RETAIL-BASED HEALTH CLINICS AND URGENT CARE CENTERS

The American Osteopathic Association recommends that retail-based health clinics and urgent care centers adhere to the following principles and standards to guide their establishment and operation (2006; reaffirmed as amended 2011; revised 2015)

1. Retail-based health clinics and urgent care centers must establish arrangements by which their health care practitioners have direct access to and supervision by physicians at levels that meet or exceed respective state laws.
2. Retail-based health clinics and urgent care centers must encourage patients to establish care with a primary care physician to ensure continuity of care. If a patient's conditions or symptoms are beyond the scope of services provided by the clinic, that patient must immediately be referred to an appropriate physician or emergency facility. Also, retail-based health clinics urgent care centers should be encouraged to use electronic health records as a means of communicating information with the patient's primary physician and facilitating continuity of care.
3. Whether by electronic communication, or some other acceptable means, retail-based health clinics urgent care centers must send detailed information on services provided to the patient's primary care physician in a timely manner to ensure continuity of care.
4. The clinic must have a well-defined and limited scope of clinical services. These services must not exceed the on-site health provider's scope of practice, as determined by state law.
5. Retail-based health clinics AND urgent care centers ~~urgent care centers~~ must use standardized medical protocols developed from evidence-based practice guidelines for non-physician practitioners.
6. Retail-based healthcare clinics AND urgent care centers must comply with all applicable standards of state and federal regulations expected of physician offices.
7. Retail-based healthcare clinics and urgent care centers must not expand into programs offering patient care for the management of chronic and complex conditions.

Retail-based healthcare clinics located in or affiliated with a pharmacy must inform patients that any medication prescribed or recommended may be purchased at the patient's pharmacy of choice.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H304-A/15 PROTECTING AMERICAN STUDENTS FROM PROFIT-DRIVEN FOREIGN MEDICAL SCHOOLS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H304-A/15 PROTECTING AMERICAN STUDENTS FROM PROFIT-DRIVEN FOREIGN MEDICAL SCHOOLS

The American Osteopathic Association will officially adopt and advocate for the position that federal student loans shall be restricted from medical schools not subject to the accreditation standards of the Commission on Osteopathic College Accreditation or the Liaison Committee on Medical Education. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H305-A/15 REMOVE FDA BAN ON ANONYMOUS SPERM DONATION FROM MEN WHO HAVE SEX WITH MEN

SUBMITTED BY: Bureau on Federal Health Programs / Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs and the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H305-A/15 REMOVE FDA BAN ON ANONYMOUS SPERM DONATION FROM MEN WHO HAVE SEX WITH MEN

The American Osteopathic Association (AOA) will call for an end to the five-year deferment period for anonymous sperm donation for men who have sex with men, and modify the exclusion criteria for men who have sex with men to be consistent with deferrals for those to be judged at an increased risk of infection. The AOA supports lobbying measures with the intention of amending this policy. 2015

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
The FDA five-year deferment period for anonymous sperm donation for men who have sex with men has been in place since 2005.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H308-A/15 IMPROVING COMPETITIVE EDGE FOR MEMBERSHIP IN THE AOA

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Membership recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H308-A/15 IMPROVING COMPETITIVE EDGE FOR MEMBERSHIP IN THE AOA

The American Osteopathic Association will review all membership dues, fees, and duration of certification to become more cost competitive with allopathic organizations to help build and maintain membership. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H312-A/15 TAX CREDIT FOR PRECEPTING

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H312-A/15 TAX CREDIT FOR PRECEPTING

The American Osteopathic Association (AOA) will SUPPORT ~~develop a template for model~~ **STATE** legislation ~~and a toolkit with strategies~~ to implement precepting tax credit**S** ~~legislation~~. 2015.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
Tax credits could be either state or federal.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H309-A/15 SITE NEUTRAL REIMBURSEMENT

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H309-A/15 SITE NEUTRAL ~~REIMBURSEMENT~~ PAYMENT

The American Osteopathic Association (AOA) **SUPPORTS** that payments from all payers should reflect the resources required to provide patient care in each setting, ~~**and therefore, may vary to the extent that documented resource differences may vary**~~.

The AOA ~~**believes**~~ **SUPPORTS** that payments for all sites of care should account for costs incurred in that setting, and should take into account the nature of the patient population served by each type of provider and other factors, such as, but not limited to, the provision of care coordination, access to after-hours care, emergency care, quality activities, and regulatory compliance costs.

The AOA ~~**believes**~~ **SUPPORTS** that efforts should be made to collect comprehensive and reliable data regarding the extent of actual cost differences among sites of service, the impact of current site of service differentials on patient access; the extent to which recent site of service shifts are attributable to payment differentials; and the potential impact of the elimination or reduction of such differentials on providers' ability to cover their reasonable costs.

The AOA ~~**believes**~~ **SUPPORTS** that pending collection of such data, private and public payers should avoid reductions in payment that create or aggravate existing site of service differentials for services that are demonstrably similar in terms of nature, scope, and patient population.

The AOA ~~**believes**~~ **SUPPORTS** that Medicare patients should be provided access to data regarding differences in copayment requirements among various sites of service. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H311-A/15 SUPPORTING THE USE OF OMM IN THE VA

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H311-A/15 SUPPORTING THE USE OF OSTEOPATHIC MANIPULATIVE MEDICINE (OMM) IN THE VETERANS ADMINISTRATION (VA)

The American Osteopathic Association (AOA) will work with the Veterans Administration (VA) to: 1) establish the position of National Osteopathic Manipulative Medicine (OMM) Director within the Veterans Administration System; 2) create National VA Regulation promoting the use of Osteopathic Manipulative Medicine; 3) create Manual Medicine Clinics; 4) to hire physicians trained in Osteopathic Manipulative Medicine, to staff manual medicine clinics within the department of Physical Medicine and Rehabilitation (PMR); 5) assist the National OMM Director in coordinating support for manual medicine clinics by encouraging Osteopathic Schools to sign Memorandum Of Understandings that allow osteopathic students and residents to rotate through the manual medicine clinics and eventually apply for jobs in these clinics on an equal opportunity basis; 6) and the AOA will work with Congress to pass any legislation required to put forth the promotion of OMM in the VA (see policy background in VHA Directive 2009-059 supporting Chiropractic Care. The AOA will continue to educate the VA on the benefit of OMM to patient care. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H313-A/15 PRACTICE RIGHTS OF OSTEOPATHIC PHYSICIANS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRM AS AMENDED.

(Old language is crossed out and new language is in CAPS)

H313-A/15 PRACTICE RIGHTS OF OSTEOPATHIC PHYSICIANS

The American Osteopathic Association and its component societies ~~be~~ **ARE** encouraged to ~~promote~~ SUPPORT OSTEOPATHIC PHYSICIANS AND THEIR PRACTICES ~~unity and the practice rights of osteopathic physicians,~~ by ~~establishing a specific Practice Rights agenda and support the development of seminars or other vehicles to carry out the following objectives~~: (1) WORKING WITH THE AMERICAN OSTEOPATHIC INFORMATION ASSOCATION TO educate physicians as to the importance of compliance, risk management, ~~at~~ AND risk agreements with managed care, billing and coding, documentation, and fraud and abuse issues. (2). IdentifyING supportive STATE AND FEDERAL agencies, PROFESSIONAL liability INSURANCE companies, and physicians with expertise ~~in~~ **ON** these issues. (3) **ENCOURAGING** ~~EncourageING government AGENCIES and insurance agencies COMPANIES to utilize only expert witnesses~~ **GOVERNMENT AGENCIES AND INSURANCE COMPANIES TO UTILIZE ONLY EXPERT WITNESSES WHO ARE OSTEOPATHIC PHYSICIANS IN PEER REVIEW, FRAUD AND ABUSE, CIVIL AND CRIMINAL CASES INVOLVING OSTEOPATHIC PHYSICIANS AND BOARDS WITH "LIKE OSTEOPATHIC SPECIALTY". (4)** ~~who are osteopathic physicians in peer review, fraud and abuse, civil and criminal cases involving osteopathic physicians and boards with "like osteopathic specialty". (4) DevelopING and a~~Advis**E**~~e~~ING ~~the~~ AOA AND STATE SOCIETY leadership ~~and state societies~~ of ~~the~~ ANY needs, trends~~,~~ ~~and~~ OR issues of concern RELATED TO THE ABOVE**,** which will ~~encourage unity, and~~ enhance the RIGHTS AND practiceS ~~rights~~ of our fellow OSTEOPATHIC physicians. ~~The AOA will take steps to address the above listed issues at the national level.~~ 1999; revised 2004; reaffirmed as amended 2009; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____

DATE _____

SUBJECT: H314-A/15 RETAIL MEDICAL CLINICS IN FACILITIES SELLING TOBACCO, NICOTINE OR VAPING PRODUCTS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H314-A/15 RETAIL MEDICAL CLINICS IN FACILITIES SELLING TOBACCO, NICOTINE OR VAPING PRODUCTS

The American Osteopathic Association discourages the placement of medical practices AND LIMITED SERVICE CLINICS in retail settings ~~and limited service health clinics~~ that promote and sell tobacco because it is contrary to the efforts and standards of the health care community at large. 2010; revised 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H315-A/15 OSTEOPATH AND OSTEOPATHY - USE OF THE TERM

SUBMITTED BY: Bureau of International Osteopathic Medicine

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of International Osteopathic Medicine recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H315-A/15 OSTEOPATH AND OSTEOPATHY - USE OF THE TERM
The American Osteopathic Association policy both officially in our publications and individually on a conversational basis, is to preferentially use the term "osteopathic physician" in place of the word "osteopath" and the term "osteopathic medicine" in place of the word "osteopathy;" and that the words "osteopath" and "osteopathy" be reserved in the United States for the following purposes: (1) previously named entities within the osteopathic medical profession; (2) historical, sentimental and informal discussions; and (3) osteopaths with a limited scope of practice. 1994; reaffirmed 2000; revised 2005; revised 2010; revised 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H317-A/15 PATIENT ACCESS IN RURAL AREAS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be SUNSET.

(Old language is crossed out and new language is in CAPS)

H317-A/15 PATIENT ACCESS IN RURAL AREAS
The American Osteopathic Association supports policy on the state and federal levels that would require all managed care health plans to have reasonably placed network physicians and hospital access; if the distance is unreasonable, the plans should pay for out of network services at no additional cost to the patient. 1995; revised 2000, 2005, 2010; revised 2015

Explanatory Statement: Submitted by Author
Submitted a new resolution for consideration by 2020 HOD that combines this policy with H635-A/16 ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE.

Background Information: Provided by AOA Staff
Current AOA Policy: H635-A/16 ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE.

Prior HOD action on similar or same topic: Policy approved in 2016.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED *(for sunset)***

DATE: **October 14, 2020**

SUBJECT: H318-A/15 PHYSICIAN OFFICE LABORATORIES

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H318-A/15 PHYSICIAN OFFICE LABORATORIES
The American Osteopathic Association supports the development and expansion of Waived Physician Office Laboratory testing and will work to ensure that physician office laboratory certification be as non-intrusive into the practice of medicine as possible; and will seek assurances that access to any laboratory tests deemed medically necessary by the physician, not be limited by unnecessary regulations. 1990; revised 1995, 2000, 2005, 2010; revised 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H319-A/15 POSTGRADUATE COMPENSATION

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H319-A/15 POSTGRADUATE COMPENSATION

The American Osteopathic Association affirms its support for ~~maintaining and~~ enhancing the quality of teaching programs, and urges Congress to provide more equitable graduate medical education funding so hospitals and other healthcare delivery systems can provide competitive compensation for postgraduate training. 1990; revised 1995; reaffirmed 2000, revised 2005, reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
Maintaining and enhancing are two separate actions which are mutually exclusive of one another.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H320-A/15 SECOND OPINION, SURGICAL CASES

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H320-A/15 SECOND OPINION, SURGICAL CASES
The American Osteopathic Association believes that AOA members who are board certified, or board eligible and qualified by their training and experience to render a second surgical opinion in any given case, be recognized and utilized as qualified and reimbursed by entities underwriting such opinions and that this policy statement in no way advocates the institution of any mandatory second surgical opinion programs, by any entity. 1980; revised 1985, 1990; reaffirmed 1995; revised 2000, 2005, revised 2010; revised 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H322-A/15 UNIFORMED SERVICES: ENDORSEMENT OF PHYSICIANS SERVING IN THE UNIFORMED SERVICES

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H322-A/15 UNIFORMED SERVICES: ENDORSEMENT OF PHYSICIANS SERVING IN THE UNIFORMED SERVICES

The American Osteopathic Association(AOA) will continue to assist the Surgeons General of the uniformed services and the American public in maintaining and assuring the highest quality of healthcare by its representatives in the uniformed services and recognizes the ~~55th~~ **ANNUAL** anniversary of osteopathic physicians being commissioned in the military. 1985; revised 1990, 1995; 2000, 2005; revised 2010; revised 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H323-A/15 EMERGENCY MEDICAL SERVICES FOR CHILDREN, SUPPORT OF

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H323-A/15 EMERGENCY MEDICAL SERVICES FOR CHILDREN, SUPPORT OF

The American Osteopathic Association (AOA) supports the availability ~~of~~ TO state of the art emergency medical care for ill and injured children and adolescents; that pediatric services are well integrated into an emergency medical service system backed by optimal resources; and the entire spectrum of emergency services, including primary prevention of illness and injury, acute care, and rehabilitation, are provided to children and adolescents as well as adults, no matter where they live, attend school or travel. The federal Emergency Medical Services for Children (EMSC) program achieves these goals and as such, AOA supports full funding and reauthorization of this program WHEN NEEDED. 2005, reaffirmed 2010; reaffirmed as revised 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____

DATE _____

SUBJECT: H324-A/15 PHYSICIAN INCENTIVES TO UNDERSERVED AREAS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H324-A/15 PHYSICIAN INCENTIVES TO UNDERSERVED AREAS

The American Osteopathic Association will ~~focus attention on potential~~ SUPPORT FEDERAL AND STATE legislation to increase physician loan repayment programs and tax deductions/~~ or tax~~ credits FOR INDIVIDUALS WHO ~~when initiating a~~ practice in underserved RURAL AND URBAN areas~~ to assist and assure an adequate supply of physicians in the future~~. 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H326-A/15 VACCINES SHORTAGES

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H326-A/15 ACCESS TO VACCINES ~~SHORTAGES~~

The American Osteopathic Association (AOA) will COMMUNICATE WITH THE CENTERS FOR DISEASE CONTROL AND PREVENTION **~~AND~~ AS WELL AS** FOOD AND DRUG ADMINISTRATION ON ISSUES RELATING TO SCHEDULE ADHERENCE AND VACCINE SHORTAGES AND WILL ENGAGE FEDERAL LAWMAKERS ON POLICY SOLUTIONS AS NEEDED**.** ~~outreach federal legislators and the Centers for Disease Control & Prevention on the critical issue of vaccine shortage.~~ The AOA will also communicate ANY ACTIONS BEING TAKEN TO URGE ~~that steps be taken to give manufacturers of vaccine immunity from lawsuits because of complications which are not due to negligence; that~~ additional U.S. companies ~~will be urged~~ to manufacture vaccines for ~~the~~ U.S. citizens~~; and that the public be provided information on potential side effects and complications of vaccines so they are fully informed and responsible for their decision to be immunized~~. 2005; revised 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H329-A/15 MEDICARE BALANCE BILLING

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H329-A/15 MEDICARE BALANCE BILLING

The American Osteopathic Association (AOA) SUPPORTS ENACTMENT OF FEDERAL LEGISLATION THAT PROMOTES EQUITABLE BALANCE BILLING PRACTICES WITHIN MEDICARE THAT FACILITATE CONTINUED PHYSICIAN PARTICIPATION IN MEDICARE. ~~**encourages federal legislation to support Medicare balance billing and take the necessary steps to initiate federal legislation to achieve balance billing for Medicare patients to support continued participation by physicians**~~. 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H332-A/15 ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be SUNSET.

(Old language is crossed out and new language is in CAPS)

H332-A/15 ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES
The American Osteopathic Association will continue to encourage the US Drug Enforcement Administration to modify rules to reduce any potential administrative barriers to electronic prescribing of controlled substances. Electronic prescribing systems should be interoperable with data collection and tracking systems for the prescribing of controlled substances. 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
The content of this resolution is already covered by H318-A/19 which was approved last year. This policy is duplicative and therefore should be sunset.

Background Information: Provided by AOA Staff
Current AOA Policy: H318-A/19 ELECTRONIC PRESCRIBING

Prior HOD action on similar or same topic: Policy reaffirmed as amended in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED *(for sunset)***

DATE: **October 14, 2020**

SUBJECT: H334-A/15 PROFESSIONAL ORGANIZATION -- PHYSICIANS CHOOSING TO WHICH THEY BELONG

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Membership recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H334-A/15 PROFESSIONAL ORGANIZATION -- PHYSICIANS CHOOSING TO WHICH THEY BELONG

The American Osteopathic Association supports all physicians having the right to choose which medical associations they join, even when the employer is paying the membership fees; and will provide the physician with a letter template stating their desire to have dues paid to an osteopathic medical association. 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author

The AOA acknowledges that the number of employed physicians is increasing each year.

The AOA strongly supports and advocates this self-determination of choice of medical association membership.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H335-A/15 PRESCRIPTION DRUG DIVERSION AND ABUSE – EDUCATION, RESEARCH, AND ADVOCACY

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H335-A/15 PRESCRIPTION DRUG DIVERSION AND ABUSE – EDUCATION, RESEARCH, AND ADVOCACY

The American Osteopathic Association (AOA) will advance knowledge and understanding of appropriate use of prescription drugs through the education of the public and osteopathic medical education at all levels.

The AOA will work with other associations representing health care professionals to educate on the indicators of potential prescription drug abuse, misuse and diversion. The AOA will encourage the Institute of Medicine and other private and public organizations/agencies to conduct further research into development of reliable outcome indicators for assessing the effectiveness of measures proposed to reduce prescription drug abuse, misuse and diversion.

The AOA will advocate for evidence-informed use of state prescription monitoring programs, tamper resistant drug formulas and support efforts to assist state osteopathic medical associations in developing physician drug abuse, misuse and diversion awareness and prevention education programs.

The AOA supports policies that do not hinder patient access to and coverage of appropriate pharmacologic and non-pharmacologic treatments. It is a right of all patients to have access to medically appropriate intervention and/or treatment for conditions, including acute and chronic pain. It is the right of all physicians, to provide medically appropriate intervention and treatment modalities that will achieve safe and effective treatment, including pain control, for all their patients.

The AOA will not support any program which limits access to prescription drugs for patients with legitimate need and will not support any program which reduces the provider's ability to inform the patient's care. In addition, it is in the best interest of all patients not to confine, or seek to regulate medications, including opioid/opiate, by limiting their use to a small number of selected specialties of medicine. This would also extend to modalities now developed, or yet to be developed, such as long-acting opioid/opiate preparations. These exclusionary strategies will limit access for patients with medical indications for therapy, complicate delivery of care, and add to pain and suffering of patients.

The AOA will continue to cooperate with the pharmaceutical industry, law enforcement, and government agencies to stop prescription drug abuse, misuse and diversion as a threat to the health and well-being of the American public.

The AOA opposes the imposition of administrative or financial deterrents that decrease access to and coverage of prescription drugs with abuse-deterrent properties. 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H336-A/15 BUPRENORPHINE MAINTENANCE TREATMENT INSURANCE COVERAGE

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Socioeconomic Affairs recommend that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H336-A/15 BUPRENORPHINE MAINTENANCE TREATMENT INSURANCE COVERAGE

The American Osteopathic Association (AOA) recommends that state Medicaid administrators remove any arbitrary and restrictive limits for buprenorphine coverage and that state Medicaid administrators and third party payers recognize that chronic disease management includes a combination of psychotherapeutic and pharmacological interventions that will yield the best outcomes for patients with opioid use disorder. 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H337-A/15 VIOLENCE AGAINST HEALTHCARE STAFF

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRM as AMENDED.

(Old language is crossed out and new language is in CAPS)

H337-A/15 VIOLENCE AGAINST HEALTHCARE STAFF
The American Osteopathic Association supports LEGISLATION TO ~~legislative change~~ hold patients and their associates (that includes friends, family, and anyone WHO ACCOMPANIES ~~that affiliates with~~ them) accountable for PHYSICAL ASSAULT AND VERBAL THREATS TO HEALTH CARE STAFF by upgrading penalties under **FEDERAL AND** relevant state ~~laws~~ **LAW AND LEGISLATION** from misdemeanors to felonies where applicable. 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H338-A/15 LOW BACK PAIN CLINICAL PRACTICE GUIDELINES, REVISION OF

SUBMITTED BY: Bureau on Osteopathic Clinical Education & Research

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Osteopathic Clinical Education & Research recommend that the following policy be REAFFIRMED:

(Old language is crossed out and new language is in CAPS)

H338-A/15 LOW BACK PAIN CLINICAL PRACTICE GUIDELINES, REVISION OF

The American Osteopathic Association approves the attached Guidelines for Patients with Low Back Pain. 2009; referred 2014; reaffirmed as amended 2015.

American Osteopathic Association Guidelines for Osteopathic Manipulative Treatment (OMT) for Patients with Low Back Pain

Executive Summary:
The American Osteopathic Association recommends that osteopathic physicians use Osteopathic manipulative treatment (OMT) in the care of patients with low back pain. Evidence from systematic reviews and meta-analyses of randomized clinical trials (Evidence Level 1a) supports this recommendation.

1. Overview material: Provide a structured abstract that includes the guideline's release date, status (original, revised, updated), and print and electronic sources.

~~**Release Date (expected) August 1, 2015.**~~ **THE CURRENT** ~~**This G**~~guideline**S ARE** ~~**is**~~ available through the AOA web site and National Guidelines Clearinghouse, AHRQ. The guideline is partially based upon the following study:

Franke H, Franke J-D, Fryer G. Osteopathic manipulative treatment for nonspecific low back pain: a systematic review and meta-analysis. BMC Musculoskeletal Disorders 2014, 15:286 doi:10.1186/1471-2474-15-286. (Published: 30 August 2014)

The format used for this guideline is in accordance with the 2013 (Revised) Criteria for Inclusion of Clinical Practice Guidelines in NGC and uses the 2011 definition of clinical practice guideline developed by the Institute of Medicine (IOM): "Clinical practice guidelines are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options".

ABSTRACT

Background
Osteopathic manipulative treatment (OMT) is a distinctive modality commonly used by osteopathic physicians to complement conventional treatment of musculoskeletal disorders, including those that cause low back pain. OMT is defined in the Glossary of Osteopathic Terminology as: "The therapeutic

application of manually guided forces by an osteopathic physician (US Usage) to improve physiologic function and/or support homeostasis that has been altered by somatic dysfunction. OMT employs a variety of techniques" (see Appendix 1 for list). Somatic dysfunction is defined as: "Impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial and myofascial structures, and their related vascular, lymphatic, and neural elements. Somatic dysfunction is treatable using osteopathic manipulative treatment."

This guideline updates the AOA guideline for osteopathic physicians to utilize OMT for patients with nonspecific acute or chronic LBP published in 2010 on the National Guideline Clearinghouse.[1]

Methods

This guideline update process commenced with literature searches that included electronic databases, personal contact with key researchers of OMT and low back pain, and internet search engines. Early in the process, the AOA discovered the systematic literature review conducted by Franke, Franke and Fryer (2014)[2] which serves as the basis for this updated guideline.

Franke et al searched electronic databases, reference lists and personal communications. Their inclusion criteria consisted of randomized clinical trials of adults (>18 years of age) with nonspecific back pain treated by osteopathic physicians or osteopaths who used their clinical judgment as opposed to a standard predetermined protocol. Studies with pregnant and postpartum participants were also included. Studies excluded from the review were those where co-interventions were not performed on both comparison groups; the OMT intervention could not be assigned an effect size; participants had specific back pain from pathology (i.e., fracture, tumor, metastasis, inflammation, infection); or the intervention consisted of a single manual technique (see Appendix 2 for the list of references in Franke et al).

The primary outcomes for the Franke et al review were pain and functional status. The authors measured pain using the visual analogue scale (VAS), number rating scale (NRS), or the McGill Pain Questionnaire. Functional status was measured using the Roland-Morris Disability Questionnaire, Oswestry- Disability Index, or other valid instrument. The point of measurement for both outcomes was the first 3 month interval.

Studies were independently reviewed using a standardized form. The mean difference (MD) or standard mean difference (SMD) with 95% confidence intervals (CIs) and overall effect size were calculated at 3 months post treatment. GRADE approach, as recommended by the updated Cochrane Back Review Group method guidelines, was used to assess quality of evidence.

Results

The authors of the systematic review identified 307 studies. Thirty-one were evaluated and 16 excluded. Of the 15 studies included in the review, 6 were retrieved from the grey literature in Germany, 5 from the United States, 2 from the United Kingdom, and 2 from Italy. Ten studies investigated effectiveness of OMT for nonspecific LBP, 3 studies examined the effect of OMT for LBP in pregnant women, and 2 studied the effect of OMT for LBP in postpartum women. All studies reported on the effect of OMT on pain, and all but one reported on back pain specific functional status. There were a total of 1502 participants included in the qualitative and quantitative analysis.

OMT significantly reduces pain and improves functional status in patients, including pregnant and postpartum women, with nonspecific acute and chronic LBP. Franke et al found that in acute and chronic non-specific LBP, moderate-quality evidence suggested OMT had a significant effect on pain relief (MD:-12.91, 95% CI: -20.00 to -5.82) and functional status (SMD:-0.36, 95%CI: -0.58 to -0.14). More specifically, in chronic nonspecific LBP, evidence suggested a significant difference in favor of OMT regarding pain (MD:-14.93, 95%CI:-25.18 to -4.68) and functional status (SMD:-0.32, CI:-0.58 to

-0.07). When examining nonspecific LBP in pregnancy, low-quality evidence suggested a significant difference in favor of OMT for pain (MD, -23.01; 95% CI, -44.13 to -1.88) and functional status (SMD, -0.80; 95% CI, - 1.36 to -0.23). Conversely for nonspecific LBP postpartum, Franke et al found that moderate-quality evidence suggested a significant difference in favor of OMT for pain (MD, -41.85; 95% CI, -49.43 to -34.27) and functional status (SMD, -1.78; 95% CI, -2.21 to -1.35).[2]

Conclusions

Clinically relevant effects of OMT were found for reducing pain and improving functional status in patients with acute and chronic nonspecific LBP and for LBP in pregnant and postpartum women at 3 months post treatment.

OMT significantly reduces low back pain. The level of pain reduction is clinically important, greater than expected from placebo effects alone, and may persist through the first year of treatment. Additional research is warranted to elucidate mechanistically how OMT exerts its effects, to determine if OMT benefits extend beyond the first year of treatment, and to assess the cost-effectiveness of OMT as a complementary treatment for low back pain.

2. Focus: Describe the primary disease/condition and intervention/service/technology that the guideline addresses. Indicate any alternative preventive, diagnostic or therapeutic interventions that were considered during development.

These guidelines are intended to assist osteopathic physicians in appropriate utilization of OMT for patients with low back pain. Other alternative preventive, diagnostic and therapeutic interventions considered during development of these guidelines were those noted in the following published guidelines for physicians caring for patients with low back pain:

> 1) Chou R, Qaseem A, Snow V, Casey D, Cross JT Jr, Shekelle P, Owens DK: Clinical Efficacy Assessment Subcommittee of the American College of Physicians, American College of Physicians, American Pain Society Low Back Pain Guidelines Panel. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. Ann Intern Med 2007 Oct 2;147(7):478-91)

BACKGROUND

Historically, low back pain has been the most common reason for visits to osteopathic physicians.[3] More recent data from the Osteopathic Survey of Health Care in America has confirmed that a majority of patients visiting osteopathic physicians continue to seek treatment for musculoskeletal conditions.[4, 5] A distinctive element of low back care provided by osteopathic physicians is osteopathic manipulative treatment (OMT). A comprehensive evaluation of spinal manipulation for low back pain undertaken by the Agency for Health Care Policy and Research in the United States concluded that spinal manipulation can be helpful for patients with acute low back problems without radiculopathy when used within the first month of symptoms.[6]Nevertheless, because most studies of spinal manipulation involve chiropractic or physical therapy,[7]it is unclear if such studies adequately reflect the efficacy of OMT for low back pain. Although the professional bodies that represent osteopaths, chiropractors, and physiotherapists in the United Kingdom developed a spinal manipulation package consisting of three common manual elements for the UK Back pain Exercise and Manipulation (UK BEAM) trial,[8] there are no data on the comparability of profession specific outcomes.[9,10] It is well known that OMT comprises a diversity of techniques.[11] These OMT techniques are not adequately represented by the UK BEAM trial package. Professional differences in spinal manipulation are more pronounced in research studies, in which chiropractors have focused almost exclusively on high-velocity-low amplitude techniques.[12] For example, a major trial of chiropractic manipulation as adjunctive treatment for childhood asthma used a high-velocity-low amplitude thrust as the active treatment.[13] The simulated

treatment provided in the sham manipulation arm of this chiropractic trial, which ostensibly was used to provide no therapeutic effect, bore a marked similarity to OMT.[12, 14] Because differences in professional background and training lend themselves to diverse manipulation approaches, clinicians have been warned about generalizing the findings of systematic reviews to practice.[15] In additional to professional differences in the manual techniques themselves, osteopathic physicians in the United States, unlike allopathic physicians or chiropractors, can treat this condition simultaneously using both conventional primary care approaches and complementary spinal manipulation. This represents a unique philosophical approach in the treatment of low back pain. Consequently, there is a need for empirical data that specifically address the efficacy of OMT for conditions such as low back pain.[16]

These guidelines are based on a systematic review of the literature on OMT for patients with low back pain and a meta-analysis of all randomized controlled trials of OMT for patients with low back pain in ambulatory settings.[2]

3. Goal: Describe the goal that following the guideline is expected to achieve, including the rationale for development of a guideline on this topic.

The goal of these guidelines is to enable osteopathic physicians as well as other physicians, other health professionals, and third party payers, to understand the evidence underlying recommendations for appropriate utilization of OMT, which is not detailed in the current sets of guidelines developed by other physicians. The American Osteopathic Association does not believe it is appropriate for other professionals to create guidelines for utilization of OMT since it is not a procedure or approach used by those physicians. It is, however, the purview and duty of the American Osteopathic Association to inform its members and the public about the appropriate utilization of OMT.

4. Users/setting: Describe the intended users of the guideline (e.g., provider types, patients) and the settings in which the guideline is intended to be used.

These guidelines are to be used by osteopathic physicians in application of OMT to patients with nonspecific low back pain, which can be defined as tension, soreness, or stiffness in the lower back region with an unidentified cause[2], in the ambulatory setting.

5. Target population: Describe the patient population eligible for guideline recommendations and list any exclusion criteria.

Patients with nonspecific low back pain of musculoskeletal origin are eligible for guideline recommendations. Patients with visceral disease conditions that refer pain to the low back are excluded from these guidelines. Other conditions of exclusion are when the following are the identified source of the low back pain: vertebral fracture; vertebral joint dislocation; muscle tears or lacerations; spinal or vertebral joint ligament rupture; inflammation of intervertebral discs, spinal zygapophyseal facets joints, muscles or fascia; skin lacerations; sacroiliitis; ankylosing spondylitis; or masses in or from the low back structures that are the source of the pain. Exclusion from this guideline does not imply that OMT is contraindicated in these conditions.

6. Developer: Identify the organization(s) responsible for guideline development and the names/credentials/potential conflicts of interest of individuals involved in the guideline's development.

American Osteopathic Association, Bureau of Osteopathic Clinical Education and Research, Task Force on the Low Back Pain Clinical Practice Guidelines: Richard J. Snow, DO, MPH, (chair), Michael Seffinger, DO, Kendi Hensel, DO, PhD, and Rodney Wiseman, DO.

7. Funding source/sponsor: Identify the funding source/sponsor and describe its role in developing and/or reporting the guideline. Disclose potential conflict of interest.

This project was funded by the American Osteopathic Association. The AOA Bureau of Osteopathic Clinical Education and Research convened a Task Force on the Low Back Pain Clinical Practice Guidelines to revise the guidelines. Upon approval of these recommendations by the AOA Board of Trustees and the AOA House of Delegates, the guidelines will be submitted to the National Guidelines Clearinghouse for public record and access. As the guidelines were developed based on the peer reviewed scientific literature, no conflict of interest is claimed by the developers. A well rounded, objective perspective is presented. Any views from an osteopathic perspective that is not supported by the scientific literature is stated and clearly identified so the reader is able to discern any potential for bias.

8. Evidence collection: Describe the methods used to search the scientific literature, including the range of dates and databases searched, and criteria applied to filter the retrieved evidence.

This guideline update process commenced with literature searches that included electronic databases, personal contact with key researchers of OMT and low back pain, and internet search engines. Early in the process, the AOA discovered the systematic literature review conducted by Franke, Franke and Fryer (2014) which serves as the basis for this updated guideline.

Franke et al[2] searched electronic reference databases, Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE, Embase, CINAHL, PEDro, OSTMED.DR, and Osteopathic Web Research using thefollowing search terms: low back pain, back pain, lumbopelvic pain, dorsalgia, osteopathic manipulative treatment, OMT, and osteopathic medicine. In addition to the listed databases, the authors conducted searches in anongoing trial database (metaRegister of Controlled Trials. To enhance their search, the authors tracked citations of identified trials, and manually searched reference lists for other relevant papers.

The authors reviewed all the studies using a standardized form, and all mean differences (MD) and standard mean differences (SMD) were calculated with 95% confidence intervals (CIs). Overall effect size was calculated at the 3month post treatment follow-up. GRADE approach, as recommended by the updated Cochrane Back Review Group method guidelines, was used to assess quality of evidence.

9. Recommendation grading criteria: Describe the criteria used to rate the quality of evidence that supports the recommendations and the system for describing the strength of the recommendations. Recommendation strength communicates the importance of adherence to a recommendation and is based on both the quality of the evidence and the magnitude of anticipated benefits or harms.

Franke et al[2] evaluated the methodological quality of the studies using the Risk of Bias tool of the Cochrane Back Review Group. Studies were scored as 'low risk', 'high risk', or 'unclear', and included assessments of randomization, blinding, baseline comparability between groups, patient compliance, and dropping out. Per the Cochrane Back Review Group, studies received a 'low risk' score when a minimum of 6 criteria were met and it was determined that the study had no serious flaws (e.g., a drop-out rate over 50%). Disagreements about the quality of the studies were resolved through discussion and consensus. Franke et al used Review Manager to analyze the data for the meta-analysis. The authors converted the NRS and VAS scores from the included studies to a 100-point scale for the pain measurement, and calculated the mean difference (MD) with 95% CIs for the random effects model.

Franke et al conducted other noteworthy analysis. They used the standard mean difference (SMD) was also used in a random effects model to determine functional status. The authors grouped the 1 study examining acute LBP and the 3 studies examining patients with both acute and chronic LBP together for the purpose of their meta-analyses. Overall, they created four groups: (1) acute and chronic LBP;

(2) chronic LBP (duration of pain more than 3 months); (3) LBP in pregnant women; and (4) LBP in postpartum women.

Franke et al also assessed the clinical relevance of each study using the Cochrane Back Review Group recommendations. A small effect was defined as MD less than 10% of the scale and SMD less than 0.5. A medium effect was defined as MD 10% to 20% of the scale and SMD from 0.5 to 0.8. A large effect was defined as MD greater than 20% of the scale and SMD greater than 0.8.

10. Method for synthesizing evidence: Describe how evidence was used to create recommendations, e.g., evidence tables, meta-analysis, decision analysis.

Due to the applicability of the Franke et al review to this updated guideline and consequently, the reliance thereon, the AOA will describe how the authors synthesized their evidence.

OMT versus other interventions for acute and chronic nonspecific low back pain

Franke et al[2] analyzed the effect of OMT for pain in acute and chronic LBP using ten studies with 12 comparison groups and 1141 participants. Six studies reported a significant effect of OMT on pain, 3 studies showed a non-significant effect, and 3 studies reported a non-significant effect in favor of the control treatment. Collectively, the studies showed moderate-quality evidence that OMT had a significant effect on pain relief (MD:-12.91, 95% CI: −20.00 to −5.82).

For functional status, the authors based their results on 9 studies with 10 comparisons groups and 1046 participants. The studies revealed moderate-quality evidence that a significant difference in favor of OMT existed (SMD:-0.36, 95%CI: −0.58 to −0.14). Four studies reported a significant effect of OMT, 3 studies reported a non- significant effect, and 1 study reported a non-significant effect in favor of the control group.

OMT versus other interventions for chronic nonspecific low back pain

For nonspecific LBP, Franke et al[2] analyzed 6 studies with 7 comparisons and 769 participants. This analysis revealed moderate-quality evidence that a significant difference in favor of OMT existed (MD:-14.93, 95%CI:-25.18 to −4.68)

For functional status outcomes, the authors reviewed 3 studies which reported a significant improvement for OMT. One study reported a non-significant effect for OMT, and 1 study reported an effect for the control group Collectively, the analysis showed moderate-quality evidence for a significant difference in favor of OMT (SMD:-0.32, CI:-0.58 to −0.07).

OMT versus usual obstetric care, sham ultrasound, and untreated for nonspecific low back pain in pregnant women

For LBP in pregnant women, the authors reviewed three studies with 4 comparisons and 242 participants. Two studies showed a significant improvement following OMT, and 1 study showed a non-significant improvement. The final analysis of these studies resulted in low- quality evidence for a significant difference in favor of OMT for LBP in pregnant women (MD, −23.01; 95% CI, −44.13 to −1.88) and functional status (SMD, −0.80; 95% CI, −1.36 to −0.23).[2]

Hensel, et al[17] found that OMT was effective for mitigating pain and functional deterioration compared with usual care only; however, OMT did not differ significantly from placebo ultrasound treatment. The authors concluded that OMT is a safe, effective adjunctive modality to improve pain and functioning during the third trimester.

OMT versus untreated for nonspecific low back pain in postpartum women

Franke et al reviewed two studies focusing on OMT for LBP in postpartum women. Both studies reported significant improvement following OMT. The moderate-quality evidence showed a significant difference in favor of OMT for pain (MD, −41.85; 95% CI, −49.43 to −34.27) and functional status (SMD, −1.78; 95% CI, −2.21 to −1.35).

DISCUSSION

Efficacy of OMT

The overall results clearly demonstrate a statistically significant reduction in low back pain with OMT. Subgroup meta-analyses to control for moderator variables demonstrated that OMT significantly reduced low back pain vs active treatment or placebo control and vs no treatment control. If it is assumed, as shown in a review[18], that the effect size is –0.27 for placebo control vs no treatment in trials involving continuous measures for pain, then the results of our study are highly congruent (i.e., effect size for OMT vs no treatment [–0.53] = effect size for OMT vs active treatment or placebo control [–0.26] + effect size for placebo control vs no treatment [–0.27]). It has been suggested that the therapeutic benefits of spinal manipulation are largely due to placebo effects.[19] A preponderance of results from our sensitivity analyses supports the efficacy of OMT vs active treatment or placebo control and therefore indicates that low back pain reduction with OMT is attributable to the manipulation techniques, not merely placebo effects. Also, as indicated above, OMT vs no treatment control demonstrated pain reductions twice as great as previously observed in clinical trials of placebo vs no treatment control.[18] The clinical significance of our findings is readily evident when compared with nonsteroidal anti-inflammatory drugs, including cyclo-oxygenase-2 inhibitors. A recent meta-analysis of the efficacy of these drugs included 23 randomized placebo controlled trials for osteoarthritic knee pain, representing over 10,000 subjects, and measured pain outcomes up to three months following randomization.[20] This study found an overall effect size of –0.32 (95% CI, –0.24 - –0.39) and effect size of –0.23 (95% CI, –0.16 - –0.31) when drug non-responders were not excluded from the analyses. Thus, our effect size of –0.26 (95% CI, –0.48 - –0.05) for OMT in trials vs active treatment or placebo control suggests that OMT provides an analgesic effect comparable to nonsteroidal anti-inflammatory drugs, including cyclo-oxygenase-2 inhibitors. Unlike the meta-analysis of nonsteroidal anti-inflammatory drugs,[20] however, Licciardone et al found that OMT also significantly reduced pain during the three to 12 month period following randomization.[21] Thus, OMT for low back pain may eliminate or reduce the need for drugs that can have serious adverse effects.[22] Because osteopathic physicians provide OMT to complement conventional treatment for low back pain, they tend to avoid substantial additional costs that would otherwise be incurred by referring patients to chiropractors or other practitioners.[23]With regard to back pain, osteopathic physicians make fewer referrals to other physicians and admit a lower percentage of patients to hospitals than allopathic physicians,[3] while also treating back pain episodes with substantially fewer visits than chiropractors.[24] Although osteopathic family physicians are less likely to order radiographs or prescribe nonsteroidal anti-inflammatory drugs, aspirin, muscle relaxants, sedatives, and narcotic analgesics for low back pain than their allopathic counterparts, osteopathic physicians have a substantially higher proportion of patients returning for follow-up back care than allopathic physicians.[25] In the United Kingdom, where general practitioners may refer patients with spinal pain to osteopaths for manipulation, it has been shown that OMT improved physical and psychological outcomes at little extra cost.[26]

Licciardone et al [27], in the OSTEOPAThic Health outcomes In Chronic low back pain (OSTEOPATHIC) Trial studied OMT and ultrasound therapy for short term relief of nonspecific chronic low back pain. The authors found that the patients receiving OMT showed moderate to substantial improvements in low back pain which met or exceeded the Cochrane Back Review Group criterion for a medium effect size in relieving chronic low back pain.

11. Prerelease review: Describe how the guideline developer reviewed and/or tested the guidelines prior to release.

Guidelines were reviewed by the Bureau of Osteopathic Clinical Education and Research, the AOA Board of Trustees, and the AOA House of Delegates.

12. Update plan: State whether or not there is a plan to update the guideline and, if applicable, an expiration date for this version of the guideline. The guidelines will be updated every 5 years.

13. Definitions: Define unfamiliar terms and those critical to correct application of the guideline that might be subject to misinterpretation.

OMT referred specifically to manual treatment provided by osteopathic physicians, or other physicians who had demonstrated training and proficiency in OMT, such as those practitioners in Europe who may have undertaken osteopathic conversion programs.

14. Recommendations and rationale: State the recommended action precisely and the specific circumstances under which to perform it. Justify each recommendation by describing the linkage between the recommendation and its supporting evidence. Indicate the quality of evidence and the recommendation strength, based on the criteria described in 9.

Based on this meta-analysis (evidence level 1a – see Table 1) of RCTs on OMT for patients with low back pain, it is recommended that OMT be utilized by osteopathic physicians for musculoskeletal causes of low back pain, i.e., to treat the diagnoses of somatic dysfunctions related to the low back pain.

Table 1. Levels of Evidence

Strength of evidence	Type of Study	Comment
1a	Systematic review with homogeneity of randomized controlled trials	Individual trials should be free of substantial variations in the directions and magnitudes of results
1b	Individual randomized controlled trial with narrow confidence interval	Confidence interval should indicate a clinically important OMT effect
1c	Differential frequency of adverse outcomes	An adverse outcome was frequently observed in patients who did not receive OMT, but was infrequently observed in patients who did receive OMT (equivalent to a small number needed to treat)
2a	Systematic review with homogeneity of cohort studies	Individual studies should be free of substantial variations in the directions and magnitudes of OMT effects

2b	Individual cohort study or low-quality randomized controlled trial	Low quality may be indicated by such factors as important differences in baseline characteristics between groups, lack of concealment of treatment allocation, and excessive losses to follow-up
3a	Systematic review with homogeneity of case-control studies	Individual studies should be free of substantial variations in the directions and magnitudes of OMT effects
3b	Individual case-control study	These should be free of substantial evidence of selection bias, information bias, or confounding variables
4	Case series and low quality cohort and case-control studies	Low quality of cohort and case control studies may be indicated by such factors as important sources of selection bias, information bias, or confounding variables
5	Expert opinion without explicit critical appraisal, or based on physiology, bench research, or "first principles"	These generally will have limited empirical data relevant to OMT effects in human populations

*Adapted from Straus SE, Richardson WS, Glasziou P, and Haynes RB, Evidence-Based Medicine. How to Practice and Teach EBM (3rd ed), 2005

15. Potential benefits and harms: Describe anticipated benefits and potential risks associated with implementation of guideline recommendations.

Potential benefits include but are not limited to improved care for patients seeing osteopathic physicians or practitioners for somatic dysfunctions causing low back pain. Harms have not been identified in randomized clinical trials on OMT for patients with low back pain. OMT for somatic dysfunction has not demonstrated harm in any clinical trials to date.

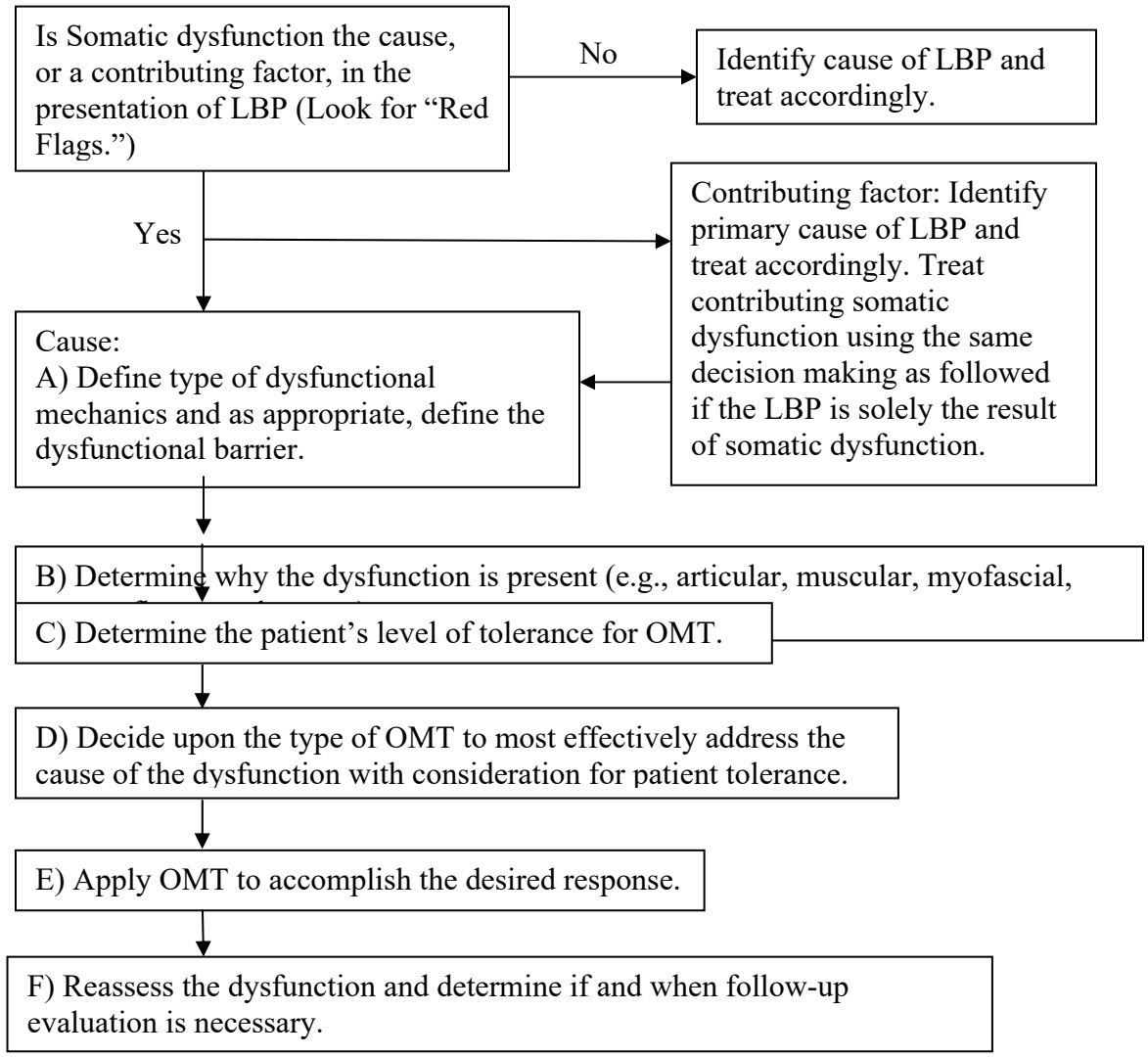
16. Patient preferences: Describe the role of patient preferences when a recommendation involves a substantial element of personal choice or values.

Patients have a choice of provider and services when they suffer from low back pain. OMT offers another option for care for low back pain from somatic dysfunction and can be provided by osteopathic physicians. It is utilized as an adjunct or complementary to conventional or alternative methods of treatment.

17. Algorithm: Provide (when appropriate) a graphical description of the stages and decisions in clinical care described by the guideline.

Once a patient with low back pain is diagnosed with somatic dysfunction as the cause, or contributing factor, of the low back pain, OMT should be utilized by the osteopathic physician. The diagnosis of somatic dysfunction entails a focal or complete history and physical exam, including an osteopathic structural exam that provides evidence of asymmetrical anatomical landmarks, restriction or altered range of joint motion, and palpatory abnormalities of soft tissues. OMT to treat somatic dysfunction is utilized after other potential causes of low back pain are ruled out or considered improbable by the treating physician; i.e., vertebral fracture; vertebral joint dislocation; muscle tears or lacerations; spinal or vertebral joint ligament rupture; inflammation of intervertebral discs, spinal zygapophyseal facets joints, muscles or fascia; skin lacerations; sacroiliitis; ankylosing spondylitis; masses in or from the low back structures; or organic (visceral) disease referring pain to the back or causing low back muscle spasms.

Algorithm for OMT LBP decision making.
Adapted from: Chapter 4. "The manipulative prescription," In: Somatic Dysfunction in Osteopathic Family Medicine. Nelson, Glonek, eds., Baltimore, MD: Lippincott, Williams & Wilkins; 2007;27-32.



↓

Follow-up, if appropriate, and repeat steps A-F.

18. Implementation considerations: Describe anticipated barriers to application of the recommendations. Provide reference to any auxiliary documents for providers or patients that are intended to facilitate implementation. Suggest review criteria for measuring changes in care when the guideline is implemented.

One of the barriers to application of the recommendations cited by osteopathic physicians has been poor reimbursement for OMT.[28] However, Medicare has reimbursed osteopathic physicians for this procedure (ICD-9 code: 98926-9), for over 30 years. Many osteopathic physicians apparently do not utilize OMT in clinical practice due to a number of barriers, including time constraints, lack of confidence, loss of skill over time from disuse, and inadequate office space.[28] Some specialists, i.e., pathologists and radiologists, do not use OMT as it is not applicable to their duties within their specialty. The AOA believes patients with low back pain should be treated with OMT given the high level of evidence that supports its efficacy. Changes in care when this guideline is implemented will be determined by physician and patient surveys, billing and coding practice patterns amongst osteopathic physicians, data gathered from osteopathic physicians via the AOA's Clinical Assessment Program, and other registry data gathering tools currently being developed by researchers.

REFERENCES

1. Clinical Guideline Subcommittee on Low Back Pain. American Osteopathic Association Guidelines for Osteopathic Manipulative Treatment (OMT) for Patients With Low Back Pain. JAOA Vol 110, No 11, November 2010.
2. Franke H, Franke J-D, Fryer G. Osteopathic manipulative treatment for nonspecific low back pain: a systematic review and meta-analysis. BMC Musculoskeletal Disorders 2014, 15:286 doi:10.1186/1471-2474-15-286. (Published: 30 August 2014)
3. Cypress BK: Characteristics of physician visits for back symptoms: a national perspective. American Journal of Public Health 1983, 73:389-395.
4. Licciardone JC, Herron KM: Characteristics, satisfaction, and perceptions of patients receiving ambulatory healthcare from osteopathic physicians: a comparative national survey. Journal of the American Osteopathic Association 2001, 101:374-385.
5. Licciardone JC: Awareness and use of osteopathic physicians in the United States: results of the Second Osteopathic Survey of Health Care in America (OSTEOSURV-II). Journal of the American Osteopathic Association 2003, 103:281-289.
6. Bigos S, Bowyer O, Braen G, et al: Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, US Department of Health and Human Services; 1994.
7. Kuchera ML, DiGiovanna EL, Greenspan PE: Efficacy and complications. In Foundations for Osteopathic Medicine. 2nd edition. Edited by Ward RC. Philadelphia, PA: Lippincott Williams & Wilkins; 2003:1143-1152.
8. Harvey E, Burton AK, Moffett JK, Breen A: Spinal manipulation for low-back pain: a treatment package agreed by the UK chiropractic, osteopathy and physiotherapy professional associations. Manual Therapy 2003, 8:46-51.
9. UK BEAM Trial Team: United Kingdom back pain exercise and manipulation (UK BEAM) randomised trial: effectiveness of physical treatments for back pain in primary care. British Medical Journal 2004, 329:1377- doi:10.1136/bmj.38282.669225.AE.
10. UK BEAM Trial Team: United Kingdom back pain exercise and manipulation (UK BEAM) randomised trial: cost effectiveness of physical treatments for back pain in primary care. British Medical Journal 2004, 329:1381- doi:10.1136/bmj.38282.607859.AE.
11. Lesho EP: An overview of osteopathic medicine. Archives of Family Medicine 1999, 8:477-484.
12. Mein EA, Greenman PE, McMillin DL, Richards DG, Nelson CD: Manual medicine diversity: research pitfalls and the emerging medical paradigm. Journal of the American Osteopathic Association 2001, 101:441-444.
13. Balon J, Aker PD, Crowther ER, et al: A comparison of active and simulated chiropractic manipulation as adjunctive treatment for childhood asthma. New England Journal of Medicine 1998, 339:1013-20.

14. Nelson CD, McMillin DL, Richards DG, Mein EA, Redwood D: Manual healing diversity and other challenges to chiropractic integration. Journal of Manipulative and Physiological Therapeutics 2000, 23:202-207.
15. Bronfort G, Haas M, Evans RL, Bouter LM: Efficacy of spinal manipulation and mobilization for low back pain and neck pain: a systematic review and best evidence synthesis. The Spine Journal 2004, 4:335-356.
16. Howell JD: The paradox of osteopathy. New England Journal of Medicine 1999, 341:1465-1468.
17. Hensel KL, Buchanan S, Brown SK, et al. Pregnancy Research on Osteopathic Manipulation Optimizing Treatment Effects: the PROMOTE study. Am J Obstet Gynecol 2014;211.
18. Hróbjartsson A, Gøtzsche PC: Is the placebo powerless? An analysis of clinical trials comparing placebo with no treatment. New England Journal of Medicine 2001, 344:1594-1602.
19. Ernst E: Does spinal manipulation have specific treatment effects? Family Practice 2000, 17:554-556.
20. Bjordal JM, Ljunggren AE, Klovning A, Slørdal L: Non-steroidal anti-inflammatory drugs, including cyclo-oxygenase-2 inhibitors, in osteoarthritic knee pain: meta-analysis of randomised placebo controlled trials. British Medical Journal 2004, 329:1317-doi:10.1136/bmj.38273.626655.63
21. Licciardone JC, Stoll ST, Fulda KG, Russo DP, Siu J, Winn W, Swift J: Osteopathic manipulative treatment for chronic low back pain: a randomized controlled trial. Spine 2003, 28:1355-1362.
22. Andersson GBJ, Lucente T, Davis AM, Kappler RE, Lipton JA, Leurgans S: A comparison of osteopathic spinal manipulation with standard care for patients with low back pain. New England Journal of Medicine 1999, 341:1426-1431.
23. Reilly BM, Hart A, Evans AT: Part II. Evidence-based medicine: a passing fancy or the future of primary care? Disease-a-Month 1998, 44:370-399.
24. Shekelle PG, Markovich M, Louie R: Factors associated with choosing a chiropractor for episodes of back pain care. Medical Care 1995, 33:842-850.
25. Hart LG, Deyo RA, Cherkin DC: Physician office visits for low back pain: frequency, clinical evaluation, and treatment patterns from a U.S. national survey. Spine 1995, 20:11-19.
26. Williams NH, Wilkinson C, Russell I, Edwards RT, Hibbs R, Linck P, Muntz R: Randomized osteopathic manipulation study (ROMANS): pragmatic trial for spinal pain in primary care. Family Practice 2003, 20:662-669.
27. Licciardone, JC, Minotti, DE, Gatchel, RJ, Kearns, CM, Singh, KP. Osteopathic Manual Treatment and Ultrasound Therapy for Chronic Low Back Pain: A Randomized Controlled Trial. Ann Fam Med 2013;11:122-129.
28. Johnson SM, Kurtz ME, Kurtz JC: Variables influencing the use of osteopathic manipulative treatment in family practice. J Am Osteopath Assoc. 1997 Feb;97(2):80-7. Erratum in: J Am Osteopath Assoc 1997 Apr;97(4):202.

Appendix 1

DEFINITION OF TERMS USED

Glossary of Osteopathic Terminology, Revised November 2011. Reprinted with permission from the American Association of Colleges of Osteopathic Medicine. All rights reserved.

To download the complete Glossary, please go to http://www.aacom.org/news-and-events/publications/glossary-of-osteopathic-terminology

osteopathic manipulative treatment (OMT): The therapeutic application of manually guided forces by an osteopathic physician (U.S. usage) to improve physiologic function and/or support homeostasis that has been altered by somatic dysfunction. OMT employs a variety of techniques including:

active method, technique in which the person voluntarily performs an osteopathic practitioner-directed motion.

articulatory treatment, (Archaic). See *osteopathic manipulative treatment, articulatory treatment system.*

articulatory (ART), a low velocity/ moderate to high amplitude technique where a joint is carried through its full motion with the therapeutic goal of increased range of movement. The activating force is either a repetitive springing motion or repetitive concentric movement of the joint through the restrictive barrier.

balanced ligamentous tension (BLT), 1. According to Sutherland's model, all the joints in the body are balanced ligamentous articular mechanisms. The ligaments provide proprioceptive information that guides the muscle response for positioning the joint, and the ligaments themselves guide the motion of the articular components. (*Foundations*) 2. First described in "Osteopathic Technique of William G. Sutherland," that was published in the *1949 Year Book of Academy of Applied Osteopathy.* See also *ligamentous articular strain.*

Chapman reflex, See *Chapman reflex.*

combined method, 1. A treatment strategy where the initial movements are indirect; as the technique is completed the movements change to direct forces. 2. A manipulative sequence involving two or more different osteopathic manipulative treatment systems (e.g., Spencer technique combined with muscle energy technique). 3. A concept described by Paul Kimberly, DO.

combined treatment, (Archaic). See *osteopathic manipulative treatment, combined method.*

compression of the fourth ventricle (CV-4), a cranial technique in which the lateral angles of the occipital squama are manually approximated slightly exaggerating the posterior convexity of the occiput and taking the cranium into sustained extension.

counterstrain (CS), 1. A system of diagnosis and treatment that considers the dysfunction to be a continuing, inappropriate strain reflex, which is inhibited by applying a position of mild strain in the direction exactly opposite to that of the reflex; this is accomplished by specific directed positioning about the point of tenderness to achieve the desired therapeutic response. 2. Australian and French use: Jones technique, (correction spontaneous by position), spontaneous release by position. 3. Developed by Lawrence Jones, DO in 1955 (originally "Spontaneous Release by Positioning," later termed "strain-counterstrain").

cranial treatment (CR), See *primary respiratory mechanism.* See *osteopathy in the cranial field.*

CV-4, abbreviation for compression of the fourth ventricle. See *osteopathic manipulative treatment, compression of the fourth ventricle.*

Dalrymple treatment, See *osteopathic manipulative treatment, pedal pump.*

direct method (D/DIR), an osteopathic treatment strategy by which the restrictive barrier is engaged and a final activating force is applied to correct somatic dysfunction.

exaggeration method, an osteopathic treatment strategy by which the dysfunctional component is carried away from the restrictive barrier and beyond the range of voluntary motion to a point of palpably increased tension.

exaggeration technique, an indirect procedure that involves carrying the dysfunctional part away from the restrictive barrier, then applying a high velocity/low amplitude force in the same direction.

facilitated oscillatory release technique (FOR), 1. A technique intended to normalize neuromuscular function by applying a manual oscillatory force, which may be combined with any other ligamentous or myofascial technique. 2. A refinement of a long-standing use of oscillatory force in osteopathic diagnosis and treatment as published in early osteopathic literature. 3. A technique developed by Zachary Comeaux, DO.

facilitated positional release (FPR), a system of indirect myofascial release treatment. The component region of the body is placed into a neutral position, diminishing tissue and joint tension in all planes, and an activating force (compression or torsion) is added. 2. A technique developed by Stanley Schiowitz, DO.

fascial release treatment, See *osteopathic manipulative treatment, myofascial release.*

fascial unwinding, a manual technique involving constant feedback to the osteopathic practitioner who is passively moving a portion of the patient's body in response to the sensation of movement. Its forces are localized using the sensations of ease and bind over wider regions.

functional method, an indirect treatment approach that involves finding the dynamic balance point and one of the following: applying an indirect guiding force, holding the position or adding compression to exaggerate position and allow for spontaneous readjustment. The osteopathic practitioner guides the manipulative procedure while the dysfunctional area is being palpated in order to obtain a continuous feedback of the physiologic response to induced motion. The osteopathic practitioner guides the dysfunctional part so as to create a decreasing sense of tissue resistance (increased compliance).

Galbreath treatment, See *osteopathic manipulative treatment, mandibular drainage.*

hepatic pump, rhythmic compression applied over the liver for purposes of increasing blood flow through the liver and enhancing bile and lymphatic drainage from the liver.

high velocity/low amplitude technique (HVLA), an osteopathic technique employing a rapid, therapeutic force of brief duration that travels a short distance within the anatomic range of motion of a joint, and that engages the restrictive barrier in one or more planes of motion to elicit release of restriction. Also known as thrust technique.

Hoover technique, 1. A form of functional method. 2. Developed by H.V. Hoover, DO. See also *osteopathic manipulative treatment, functional technique.*

indirect method (I/IND), a manipulative technique where the restrictive barrier is disengaged and the dysfunctional body part is moved away from the restrictive barrier until tissue tension is equal in one or all planes and directions.

inhibitory pressure technique, the application of steady pressure to soft tissues to reduce reflex activity and produce relaxation.

integrated neuromusculoskeletal release (INR), a treatment system in which combined procedures are designed to stretch and reflexly release patterned soft tissue and joint-related restrictions. Both direct and indirect methods are used interactively.

Jones technique, See *osteopathic manipulative treatment, counterstrain.*

ligamentous articular strain technique (LAS), 1. A manipulative technique in which the goal of treatment is to balance the tension in opposing ligaments where there is abnormal tension present. 2. A set of myofascial release techniques described by Howard Lippincott, DO, and Rebecca Lippincott, DO. 3. Title of reference work by Conrad Speece, DO, and William Thomas Crow, DO.

liver pump, See *hepatic pump.*

lymphatic pump, 1. A term used to describe the impact of intrathoracic pressure changes on lymphatic flow. This was the name originally given to the thoracic pump technique before the more extensive physiologic effects of the technique were recognized. 2. A term coined by C. Earl Miller, DO.

mandibular drainage technique, soft tissue manipulative technique using passively induced jaw motion to effect increased drainage of middle ear structures via the eustachian tube and lymphatics.

mesenteric release technique (mesenteric lift), technique in which tension is taken off the attachment of the root of the mesentery to the posterior body wall. Simultaneously, the abdominal contents are compressed to enhance venous and lymphatic drainage from the bowel.

muscle energy, a form of osteopathic manipulative diagnosis and treatment in which the patient's muscles are actively used on request, from a precisely controlled position, in a specific direction, and against a distinctly executed physician counterforce. First described in 1948 by Fred Mitchell, Sr, DO.

myofascial release (MFR), a system of diagnosis and treatment first described by Andrew Taylor Still and his early students, which engages continual palpatory feedback to achieve release of myofascial tissues.

> **direct MFR,** a myofascial tissue restrictive barrier is engaged for the myofascial tissues and the tissue is loaded with a constant force until tissue release occurs.
>
> **indirect MFR**, the dysfunctional tissues are guided along the path of least resistance until free movement is achieved.

myofascial technique, any technique directed at the muscles and fascia. See also *osteopathic manipulative treatment, myofascial release.* See also *osteopathic manipulative treatment, soft tissue technique.*

myotension, a system of diagnosis and treatment that uses muscular contractions and relaxations under resistance of the osteopathic practitioner to relax, strengthen or stretch muscles, or mobilize joints.

Osteopathy in the Cranial Field (OCF), 1. A system of diagnosis and treatment by an osteopathic practitioner using the primary respiratory mechanism and balanced membranous tension. See also *primary respiratory mechanism.* 2. Refers to the system of diagnosis and treatment first described by William G. Sutherland, DO. 3. Title of reference work by Harold Magoun, Sr, DO.

passive method, based on techniques in which the patient refrains from voluntary muscle contraction.

pedal pump, a venous and lymphatic drainage technique applied through the lower extremities; also called the pedal fascial pump or Dalrymple treatment.

percussion vibrator technique, 1. A manipulative technique involving the specific application of mechanical vibratory force to treat somatic dysfunction. 2. An osteopathic manipulative technique developed by Robert Fulford, DO.

positional technique, a direct segmental technique in which a combination of leverage, patient ventilatory movements and a fulcrum are used to achieve mobilization of the dysfunctional segment. May be combined with springing or thrust technique.

progressive inhibition of neuromuscular structures (PINS), 1. A system of diagnosis and treatment in which the osteopathic practitioner locates two related points and sequentially applies inhibitory pressure along a series of related points. 2. Developed by Dennis Dowling, DO.

range of motion technique, active or passive movement of a body part to its physiologic or anatomic limit in any or all planes of motion.

soft tissue (ST), A system of diagnosis and treatment directed toward tissues other than skeletal or arthrodial elements.

soft tissue technique, a direct technique that usually involves lateral stretching, linear stretching, deep pressure, traction and/or separation of muscle origin and insertion while monitoring tissue response and motion changes by palpation. Also called myofascial treatment.

Spencer technique, a series of direct manipulative procedures to prevent or decrease soft tissue restrictions about the shoulder. See also *osteopathic manipulative treatment (OMT), articulatory treatment (ART).*

splenic pump technique, rhythmic compression applied over the spleen for the purpose of enhancing the patient's immune response. See also *osteopathic manipulative treatment (OMT), lymphatic pump.*

spontaneous release by positioning, See *osteopathic manipulative treatment, counterstrain.*

springing technique, a low velocity/ moderate amplitude technique where the restrictive barrier is engaged repeatedly to produce an increased freedom of motion. See also *osteopathic manipulative treatment, articulatory treatment system.*

Still Technique, 1. Characterized as a specific, non-repetitive articulatory method that is indirect, then direct. 2. Attributed to A.T. Still. 3. A term coined by Richard Van Buskirk, DO, PhD.

Strain-Counterstrain,® 1. An osteopathic system of diagnosis and indirect treatment in which the patient's somatic dysfunction, diagnosed by (an) associated myofascial tenderpoint(s), is treated by using a passive position, resulting in spontaneous tissue release and at least 70 percent decrease in tenderness. 2. Developed by Lawrence H. Jones, DO, in 1955. See *osteopathic treatments, counterstrain.*

thoracic pump, 1. A technique that consists of intermittent compression of the thoracic cage. 2. Developed by C. Earl Miller, DO.

thrust technique (HVLA), See *osteopathic manipulative treatment, high velocity/low amplitude technique (HVLA).*

toggle technique, short lever technique using compression and shearing forces.

traction technique, a procedure of high or low amplitude in which the parts are stretched or separated along a longitudinal axis with continuous or intermittent force.

v-spread, technique using forces transmitted across the diameter of the skull to accomplish sutural gapping.

ventral techniques, See *osteopathic manipulative treatment, visceral manipulation.*

visceral manipulation (VIS), a system of diagnosis and treatment directed to the viscera to improve physiologic function. Typically, the viscera are moved toward their fascial attachments to a point of fascial balance. Also called ventral techniques.

somatic dysfunction: Impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial and myofascial structures, and their related vascular, lymphatic, and neural elements. Somatic dysfunction is treatable using osteopathic manipulative treatment.

Appendix 2

References cited in Franke et al systematic review

1. van Tulder M, Becker A, Bekkering T, Breen A, del Real MT, Hutchinson A, Koes B, Laerum E, Malmivaara A, Care CBWGoGftMoALBPiP: Chapter 3. European guidelines for the management of acute nonspecific low back pain in primary care. Eur Spine J 2006, 15(Suppl 2):S169–S191.
2. Airaksinen O, Brox JI, Cedraschi C, Hildebrandt J, Klaber-Moffett J, Kovacs F, Mannion AF, Reis S, Staal JB, Ursin H, Zanoli G: Chapter 4. European guidelines for the management of chronic nonspecific low back pain. Eur Spine J 2006, 15(Suppl 2):S192– S300.
3. Deyo RA, Weinstein JN: Low back pain. N Engl J Med 2001, 344:363–370.
4. National Collaborating Centre for Primary Care: Low Back Pain: Early Management of Persistent Non-specific Low Back Pain. NICE Clinical Guideline 88. London: National Institute for Health and Clinical Excellence; 2009. http://www.nice.org.uk/nicemedia/pdf/CG88NICEGuideline.pdf.
5. Burton AK, Balague F, Cardon G, Eriksen HR, Henrotin Y, Lahad A, Leclerc A, Muller G, van der Beek AJ: Chapter 2. European guidelines for prevention in low back pain. Eur Spine J 2006, 15(Suppl 2):S136–S168.
6. Dagenais S, Caro J, Haldeman S: A systematic review of low back pain cost of illness studies in the United States and internationally. Spine J 2008, 8:8–20.
7. Croft P, Papageorgiou A: Low back pain in the community and in hospitals. A report to the Clinical Standards Advisory Group of the Department of Health, Arthritis and Rheumatism Council. Manchester: Epidemiology Research Unit University of Manchester; 1994.
8. Vermani E, Mittal R, Weeks A: Pelvic girdle pain and low back pain in pregnancy: a review. Pain Pract 2010, 10:60–71.
9. Vleeming A, Albert HB, Ostgaard HC, Sturesson B, Stuge B: European guidelines for the diagnosis and treatment of pelvic girdle pain. Eur Spine J 2008, 17:794–819.
10. Gutke A, Ostgaard HC, Oberg B: Predicting persistent pregnancy-related low back pain. Spine 2008, 33:E386–E393.
11. Ostgaard HC, Zetherstrom G, Roos-Hansson E, Svanberg B: Reduction of back and posterior pelvic pain in pregnancy. Spine 1994, 19:894–900.
12. Sabino J, Grauer JN: Pregnancy and low back pain. Curr Rev Musculoskelet Med 2008,1:137–141.
13. Majchrzycki M, Mrozikiewicz PM, Kocur P, Bartkowiak-Wieczorek J, Hoffmann M, Stryla W, Seremak-Mrozikiewicz A, Grzeskowiak E: Low back pain in pregnant women. Ginekol Pol 2010, 81:851–855.
14. Gutke A, Ostgaard HC, Oberg B: Association between muscle function and low back pain in relation to pregnancy. J Rehabil Med 2008, 40:304–311.
15. Brown S, Lumley J: Maternal health after childbirth: results of an Australian population based survey. Br J Obstet Gynaecol 1998, 105:156–161.
16. MacArthur C, Lewis M, Knox EG: Health after childbirth. Br J Obstet Gynaecol 1991,98:1193–1195.
17. Patel RR, Peters TJ, Murphy DJ: Is operative delivery associated with postnatal back pain at eight weeks and eight months? a cohort study. Acta Obstet Gynecol Scand 2007, 86:1322–1327.
18. Saurel-Cubizolles MJ, Romito P, Lelong N, Ancel PY: Women's health after childbirth: a longitudinal study in France and Italy. BJOG 2000, 107:1202–1209.
19. DiGiovanna EL, Schiowitz S, Dowling DJ: An Osteopathic Approach to Diagnosis & Treatment. 3rd edition. Philadelphia: Lippincott William & Wilkins; 2005.
20. Vaughan B, Morrison T, Buttigieg D, Macfarlane C, Fryer G: Approach to low back pain - osteopathy. Aust Fam Physician 2014, 43:197–198.
21. Greenman PE: Principles of Manual Medicine. 3rd edition. Philadelphia: Lippincott William & Wilkins; 2003.

22. Maniadakis N, Gray A: The economic burden of back pain in the UK. Pain 2000, 84:95–103.
23. Fawkes CA, Leach CM, Mathias S, Moore AP: A profile of osteopathic care in private practices in the United Kingdom: a national pilot using standardised data collection. Man Ther. in press.
24. General Osteopathic Council: Snapshot Survey. London, UK: General Osteopathic Council; 2001. http://www.osteopathy.org.uk/uploads/survey2snapshot_survery_results_2001.pdf.
25. Walker BF, Muller R, Grant WD: Low back pain in Australian Adults. health provider utilization and care seeking. J Manipulative Physiol Ther 2004, 27:327–335.
26. Orrock P: Profile of members of the Australian Osteopathic Association: part 2 - the patients. Int J Osteopath Med 2009, 12:128–139.
27. Licciardone JC: The epidemiology and medical management of low back pain during ambulatory medical care visits in the United States. Osteopath Med Prim Care 2008, 2:11.
28. Licciardone JC, Brimhall AK, King LN: Osteopathic manipulative treatment for low back pain: a systematic review and meta-analysis of randomized controlled trials. BMC Musculoskelet Disord 2005, 6:43.
29. Franke H: Why reservations remain: a critical reflection about the systematic review and meta-analysis "Osteopathic manipulative treatment for low back pain" by Licciardone et al. J Bodyw Mov Ther 2012, 16:411–415.
30. Orrock PJ, Myers SP: Osteopathic intervention in chronic non-specific low back pain: a systematic review. BMC Musculoskelet Disord 2013, 14:129.
31. Higgins JPT, Green S: Cochrane Handbook for Systematic Reviews of Interventions Version 5.1.0. Cochrane Collaboration; 2011. www.cochrane-handbook.org.
32. Rubinstein SM, Terwee CB, Assendelft WJ, de Boer MR, van Tulder MW: Spinal manipulative therapy for acute low back pain: an update of the cochrane review. Spine 2013, 38:E158–E177.
33. Rubinstein SM, van Middelkoop M, Assendelft WJ, de Boer MR, van Tulder MW: Spinal manipulative therapy for chronic low-back pain: an update of a Cochrane review. Spine 2011, 36:E825–E846.
34. Johnson SM, Kurtz ME: Osteopathic manipulative treatment techniques preferred by contemporary osteopathic physicians. J Am Osteopath Assoc 2003, 103:219–224.
35. Orrock P: Profile of members of the Australian Osteopathic Association: part 1 - the practitioners. Int J Osteopath Med 2009, 12:14–24.
36. Fryer G, Johnson JC, Fossum C: The use of spinal and sacroiliac joint procedures within the British osteopathic profession. part 2: treatment. Int J Osteopath Med 2010, 13:152–159.
37. Hozo SP, Djulbegovic B, Hozo I: Estimating the mean and variance from the median, range, and the size of a sample. BMC Med Res Methodol 2005, 5:13.
38. Furlan AD, Pennick V, Bombardier C, van Tulder M: 2009 updated method guidelines for systematic reviews in the Cochrane Back Review Group. Spine (Phila Pa 1976) 2009, 34:1929–1941.
39. Cruser dA, Maurer D, Hensel K, Brown S, White K, Stoll S: A randomized, controlled trial of osteopathic manipulative treatment for acute low back pain in active duty military personnel. J Man Manip Ther 2012, 20:5–15.
40. Andersson GB, Lucente T, Davis AM, Kappler RE, Lipton JA, Leurgans S: A comparison of osteopathic spinal manipulation with standard care for patients with low back pain. N Engl J Med 1999, 341:1426–1431.
41. Gibson T, Grahame R, Harkness J, Woo P, Blagrave P, Hills R: Controlled comparison of short-wave diathermy treatment with osteopathic treatment in non-specific low back pain. Lancet 1985, 1:1258–1261.
42. Heinze G: The Effectiveness of a Holistic Osteopathic Treatment in Subacute Low Back Pain. A Randomized Controlled Trial, Unpublished D.O. Thesis. Akademie für Osteopathie; 2006. http://www.osteopathic-research.com/index.php?option=com_jresearch&view= publication&task=show&id=13797&l ang=en. 43. Kunz R, Djulbegovic B, Schunemann HJ, Stanulla M, Muti P, Guyatt G: Misconceptions, challenges, uncertainty, and progress in guideline recommendations. Semin Hematol 2008, 45:167–175.
43. Guyatt GH, Oxman AD, Schunemann HJ, Tugwell P, Knottnerus A: GRADE guidelines: a new series of articles in the Journal of Clinical Epidemiology. J Clin Epidemiol 2011, 64:380–382.
44. Liberati A, Altman DG, Tetzlaff J, Mulrow C, Gotzsche PC, Ioannidis JP, Clarke M, Devereaux PJ, Kleijnen J, Moher D: The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate healthcare interventions: explanation and elaboration. BMJ 2009, 339:b2700.
45. Adorjàn-Schaumann K, Höhrhan G, Wille H, Wolff A: Osteopathic Treatment of Chronic Low Back Pain. A Randomized Controlled Trial, Unpublished D.O. Thesis. Akademie für Osteopathie; 1999. http://www.osteopathic-research.com/index.php?option=com_jresearch&view= publication&task=show&id=13311&l ang=en.
46. Chown M, Whittamore L, Rush M, Allan S, Scott D, Archer M: A prospective study of patients with chronic back pain randomised to group exercise, physiotherapy or osteopathy. Physiother 2008, 94:21–28.
47. Gundermann S: Effectiveness of Osteopathic Treatment in Pregnant Women Suffering From Low Back Pain. A Randomized Controlled Trial, Unpublished D.O. Thesis. Akademie für Osteopathie; 2013. http://www.osteopathic-research.com/index.php?option= com_jresearch&view=publication&task=show&id=15363&l ang=en.

48. Licciardone JC, Buchanan S, Hensel KL, King HH, Fulda KG, Stoll ST: Osteopathic manipulative treatment of back pain and related symptoms during pregnancy: a randomized controlled trial. Am J Obstet Gynecol 2009, 202:43–48.
49. Licciardone JC, Minotti DE, Gatchel RJ, Kearns CM, Singh KP: Osteopathic manual treatment and ultrasound therapy for chronic low back pain: a randomized controlled trial. Ann Fam Med 2013, 11:122–129.
50. Licciardone JC, Stoll ST, Fulda KG, Russo DP, Siu J, Winn W, Swift J Jr: Osteopathic manipulative treatment for chronic low back pain: a randomized controlled trial. Spine (Phila Pa 1976) 2003, 28:1355–1362.
51. Mandara A, Fusaro A, Musicco M, Bado F: A randomised controlled trial on the effectiveness of osteopathic manipulative treatment of chronic low back pain (abstract). Int J Osteopath Med 2008, 11:156.
52. Peters R, Van Der Linde M: Osteopathic Treatment of Women with Low Back Pain during Pregnancy. A Randomized Controlled Trial, Unpublished D.O. Thesis. : Akademiefür Osteopathie; 2006. http://www.osteopathic-research.com/index.php?option= com_jresearch&view=publication&task=show&id=13801&l ang=en.
53. Recknagel C, Roá J: Study on the Effectiveness of Osteopathic Treatment for Women with Persistent Post Partum Back Pain. A Randomized Controlled Trial, Unpublished D.O. Thesis. Akademie für Osteopathie; 2007. http://www.osteopathic- research.com/index.php?option =com_jresearch&view=publication&task=show&id=13395&l ang=en.
54. Schwerla F, Rother K, Rother D, Ruetz M: Osteopathic treatment of women with persistent low back / pelvic girdle pain postpartum. In Vol Proceedings of the 9th International Symposium of Osteopathy 2012. Nantes, France: Akademie für Osteopathie; 2012. http://www.osteopathic-research.com/index.php?option=com_jresearch&view=publication&task=show&id=15181&l ang=en.
55. Vismara L, Cimolin V, Menegoni F, Zaina F, Galli M, Negrini S, Villa V, Capodaglio P: Osteopathic manipulative treatment in obese patients with chronic low back pain: a pilot study. Man Ther 2012, 17:451–455.
56. Boesler D, Warner M, Alpers A, Finnerty EP, Kilmore MA: Efficacy of high-velocity low-amplitude manipulative technique in subjects with low-back pain during menstrual cramping. J Am Osteopath Assoc 1993, 93:203–204.
57. Cleary C, Fox JP: Menopausal symptoms: an osteopathic investigation. Complement Ther Med 1994, 2:181–186.
58. Hoehler FK, Tobis JS, Buerger AA: Spinal manipulation for low back pain. JAMA 1981, 245:1835–1838.
59. Tozzi P, Bongiorno D, Vitturini C: Low back pain and kidney mobility: local osteopathic fascial manipulation decreases pain perception and improves renal mobility. J Bodyw Mov Ther 2012, 16:381–391.
60. Caragan C, Tang PY, Slack M, Leiber JD, Koskinen J, Zust D, Cragun T: Pilot clinical study of osteopathic manipulative treatment in pregnant patients with acute low back pain. Int J Osteopath Med 2008, 11:155.
61. Hoffman KS, Hoffman LL: Effects of adding sacral base leveling to osteopathic manipulative treatment of back pain: a pilot study. J Am Osteopath Assoc 1994, 94:216–217.
62. Parker J, Heinking KP, Kappler RE: Efficacy of osteopathic manipulative treatment for low back pain in euhydrated and hypohydrated conditions: a randomized crossover trial. J Am Osteopath Assoc 2012, 112:276–284.
63. Williams NH, Wilkinson C, Russell I, Edwards RT, Hibbs R, Linck P, Muntz R: Randomized osteopathic manipulation study (ROMANS): pragmatic trial for spinal pain in primary care. Fam Pract 2003, 20:662–669.
64. MacDonald RS, Bell CM: An open controlled assessment of osteopathic manipulation in nonspecific low-back pain. Spine (Phila Pa 1976) 1990, 15:364–370.
65. Williams NH, Edwards RT, Linck P, Muntz R, Hibbs R, Wilkinson C, Russell I, Russell D, Hounsome B: Cost-utility analysis of osteopathy in primary care: results from a pragmatic randomized controlled trial. Fam Pract 2004, 21:643–650.
66. Kirk L, Underwood M, Chappell L, Martins-Mendez M, Thomas P: The effect of osteopathy in the treatment of chronic low back pain. A feasibility study. Int J Osteopath Med 2005, 8:5–11.
67. Burton AK, Tillotson KM, Cleary J: Single-blind randomised controlled trial of chemonucleolysis and manipulation in the treatment of symptomatic lumbar disc herniation. Eur Spine J 2000, 9:202–207.
68. Posadzki P, Ernst E: Osteopathy for musculoskeletal pain patients: a systematic review of randomized controlled trials. Clin Rheumatol 2011, 30:285–291.
69. Walker BF, French SD, Grant W, Green S: A Cochrane review of combined chiropractic interventions for low-back pain. Spine 2011, 36:230–242.

Explanatory Statement: Submitted by Author

None provided.

Explanatory Statement: Reference Committee

RECOMMEND THAT REFERENCES BE UPDATED PRIOR TO THE NEXT PUBLICATION OF THE RESOLUTION

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: ADDRESSING THE EFFECTS OF CLIMATE ON NATIONAL HEALTH

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, rising average temperatures will lead to increased frequency and longevity of heat waves[2]; and

WHEREAS, these environmental changes will translate to poorer health outcomes in the United States—projections show, within the next 80 years, additional deaths due to climate change may reach up to tens of thousands per year[1]; and

WHEREAS, these deaths will not be offset by a smaller reduction in cold-related deaths in winter months[1]; and

WHEREAS, exposure to extreme heat can lead to heat stroke and dehydration, as well as cardiovascular, respiratory, and cerebrovascular disease[4]; and

WHEREAS, certain patient populations will be more vulnerable to extreme heat due to impaired heat regulatory functions, including young children, pregnant women, the elderly, and persons with inherent medical conditions and/or disabilities [1]; and

WHEREAS, climate change is projected to increase the vulnerability of urban populations to heat-related health impacts in the future[1]; and

WHEREAS, metropolitan areas such as St. Louis, Philadelphia, Chicago, and Cincinnati have already seen notable increases in death rates during heat waves[2]; and

WHEREAS, warmer temperatures are associated with periods of stagnant air, leading to increases in air pollution and associated health effects[2]: asthma attacks and other respiratory and cardiovascular health effects[1]: and

WHEREAS, wildfires, which are expected to continue to increase in number and severity as the climate changes, create smoke and other air pollutants[1]: and

WHEREAS, despite significant improvements in U.S. air quality since the 1970s, as of 2014 about 57 million Americans lived in counties that did not meet national air quality standards[5]; and

WHEREAS, scientists predict warmer temperatures from climate change will increase the frequency of days with unhealthy levels of ground-level ozone, a harmful air pollutant, and a component in smog[1]; and

WHEREAS, people exposed to higher levels of ground-level ozone are at greater risk of dying prematurely or being admitted to the hospital for respiratory problems[1]; and

WHEREAS, ground-level ozone can damage lung tissue, reduce lung function, and inflame airways: increasing national incidences of asthma or other lung diseases[1]; and

WHEREAS, children, older adults, outdoor workers, and those with asthma and other chronic lung diseases are particularly at risk[5]; and

WHEREAS, warm, stagnant air tends to increase the formation of ozone, therefore, climate change is likely to increase levels of ground-level ozone in already-polluted areas of the United States, thereby further decreasing air quality[1]; and

WHEREAS, the higher concentrations of ozone due to climate change may result in tens to thousands of additional ozone-related illnesses and premature deaths per year by 2030 in the United States, assuming no change in projected air quality policies[1]; and

WHEREAS, climate-related changes in stagnant air episodes, wind patterns, emissions from vegetation and the chemistry of atmospheric pollutants will also affect particulate matter levels[1]; and

WHEREAS, inhaling fine particles can lead to a broad range of adverse health effects, including lung cancer, chronic obstructive pulmonary disease (COPD), and cardiovascular disease[1]; and

WHEREAS, allergic illnesses, including hay fever, affects roughly one-third of the U.S. population, and more than 34 million Americans have been diagnosed with asthma[1]; and

WHEREAS, pollen season in the United States is occurring earlier and increasing in season duration, especially for vegetation with highly allergenic pollen, such as ragweed[1]; and

WHEREAS, rising carbon dioxide concentrations and temperatures may also lead to earlier flowering, more flowers, and increased pollen levels in ragweed[4]; and

WHEREAS, increases in the frequency or severity of some extreme weather events, such as extreme precipitation, flooding, droughts, and storms, threaten the health of people during and after the event[1]; and

WHEREAS, extreme environmental events caused by climate change can affect human health by damaging roads and bridges, disrupting access to hospitals and pharmacies[1]; and

WHEREAS, extreme environmental events caused by climate change can affect human health by interrupting communication, utility, and access to health care services[1]; and

WHEREAS, extreme environmental events caused by climate change can affect human health by reducing the availability of food and drinking water[1]; and

WHEREAS, runoff and flooding resulting from increased precipitation, hurricane rainfall, and storm surge will increasingly contaminate water bodies used for recreation (such as lakes and beaches), shellfish harvesting waters, and sources of drinking water[1]; and

WHEREAS, health impacts may include gastrointestinal illness, negative effects on the body's nervous and respiratory systems, or liver and kidney damage[1]; and

WHEREAS, extreme weather events and storm surges can damage or exceed the capacity of water infrastructure (such as drinking water or wastewater treatment plants), increasing the risk that people will be exposed to contaminants[1]; and

WHEREAS, extreme environmental events caused by climate change can affect human health by contributing to carbon monoxide poisoning from improper use of portable electric generators during and after storms[1]; and

WHEREAS, changes in temperature and precipitation, such as droughts and floods, could reduce agricultural output and increasing incidences of malnutrition in the United States[7]; and

WHEREAS, higher air temperature can increase morbidity and mortality of Salmonella and other bacteria-related food poisoning because bacteria grow more rapidly in warm environments[1]; and

WHEREAS, climate change will have a variety of impacts that may increase the risk of exposure to chemical contaminants in food[1]; and

WHEREAS, higher concentrations of carbon dioxide in the air lowers the levels of protein and essential minerals in crops such as wheat, rice, and potatoes, making these foods less nutritious[1]; and

WHEREAS, extreme environmental events caused by climate change can affect human health by creating or worsening mental health impacts such as depression and post-traumatic stress disorder (PTSD)[1]; and

WHEREAS, individuals with mental illness are especially vulnerable to extreme heat; studies have found that having a pre-existing mental illness tripled the risk of death during heat waves[1]; and

WHEREAS, the perceived threat of climate change (from news sources and/or social media) can influence stress responses and mental health[1]; and

WHEREAS, some groups of people are at higher risk for mental health impacts, such as children and older adults, pregnant and postpartum women, people with pre-existing mental illness, people with low incomes, and emergency workers[1]; and

WHEREAS, the geographic range of ticks that carry Lyme disease is limited by temperature[1]; and

WHEREAS, as air temperatures rise, ticks are likely to become active earlier in the season, and their range is likely to continue to expand northward[1]; and

WHEREAS, the risks for climate-sensitive diseases can be much higher in poorer communities with fewer resources to prevent and treat illness[6]; and

WHEREAS, communities of color (including Indigenous communities as well as specific racial and ethnic groups), low income, immigrants, and limited English proficiency face disproportionate vulnerabilities due to a wide variety of factors, such as higher risk of exposure, socioeconomic and educational factors that affect their adaptive capacity, and a higher prevalence of medical conditions that affect their sensitivity[1]; and

WHEREAS, children are vulnerable to many health risks due to biological sensitivities and more opportunities for exposure (due to activities such as playing outdoors)[1]; and

WHEREAS, occupational groups, such as outdoor workers, paramedics, firefighters, and transportation workers, as well as workers in hot indoor work environments, will be especially vulnerable to extreme heat and exposure to vector borne diseases[1]; and

WHEREAS, people with chronic medical conditions are typically vulnerable to extreme heat, especially if they are taking medications that make it difficult to regulate body temperature[1]; and

WHEREAS, there must be a just transition for all communities and workers to ensure economic security for people and communities that have historically relied on fossil fuel industry; and

WHEREAS, there must be justice and equity for frontline communities by prioritizing investment, training, climate and community resiliency, economic and environmental benefits in these communities; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) recognizes climate change as a public health crisis; and, be it further

RESOLVED, that the AOA publicly endorse legislation that includes provisions such as a plan to create an ecologically friendly economy and infrastructure; and, be it further

RESOLVED, that the AOA joins the U.S. Call to Action.

Explanatory Statement: Submitted by Author:

The US Call to Action is an organization that calls "on government, business, and civil society leaders, elected officials, and candidates for office to recognize climate change as a health emergency and to work across government agencies and with communities and businesses to prioritize action on this Climate, Health and Equity Policy Action Agenda."

References

1. USGCRP (2016). Impacts of Climate Change on Human Health in the United States: A Scientific Assessment. Crimmins, A., J. Balbus, J.L. Gamble, C.B. Beard, J.E. Bell, D. Dodgen, R.J. Eisen, N.Fann, M.D. Hawkins, S.C. Herring, L. Jantarasami, D.M. Mills, S. Saha, M.C. Sarofim, J.Trtanj, and L.Ziska, Eds. U.S. Global Change Research Program, Washington, DC. 312 pp. dx.doi.org/10.7930/J0R49NQX.
2. USGCRP (2016). Luber, G., K. Knowlton, J. Balbus, H. Frumkin, M. Hayden, J. Hess, M. McGeehin, N. Sheats, L. Backer, C. B. Beard, K. L. Ebi, E. Maibach, R. S. Ostfeld, C. Wiedinmyer, E. Zielinski-Gutiérrez, and L. Ziska, 2014: Ch. 9: Human Health. Climate Change Impacts in the United States: The Third National Climate Assessment, J. M. Melillo, Terese

(T.C.) Richmond, and G. W. Yohe, Eds., U.S. Global Change Research Program, 220-256. doi:10.7930/J0PN93H5.
3. USGCRP (2009). Global Climate Change Impacts in the United States. Karl, T.R., J.M. Melillo, and T.C. Peterson (eds.). United States Global Change Research Program. Cambridge University Press, New York, NY, USA.
4. CCSP (2008). Analyses of the effects of global change on human health and welfare and human systems. A Report by the U.S. Climate Change Science Program and the Subcommittee on Global Change Research. Gamble, J.L. (ed.), K.L. Ebi, F.G. Sussman, T.J. Wilbanks, (Authors). U.S. Environmental Protection Agency, Washington, DC, USA.
5. EPA (2014). Air Quality Trends. Accessed March 1, 2016.
6. IPCC (2014). Climate Change 2014: Synthesis Report. Contribution of Working Groups I, II and III to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change [Core Writing Team, R.K. Pachauri and L.A. Meyer (eds.)]. IPCC, Geneva, Switzerland, 151 p. (PDF, 80 pp, 4.6MB).
7. USDA (2015). Climate Change, Global Food Security, and the U.S. Food System. Brown, M.E., J.M. Antle, P. Backlund, E.R. Carr, W.E. Easterling, M.K. Walsh, C. Ammann, W. Attavanich, C.B. Barrett, M.F. Bellemare, V. Dancheck, C. Funk, K. Grace, J.S.I. Ingram, H. Jiang, H. Maletta, T. Mata, A. Murray, M. Ngugi, D. Ojima, B. O'Neill, and C. Tebaldi, 146 p

Explanatory Statement: Reference Committee

Intent of resolution needs to be clarified; second RESOLVED references legislation that is not defined; third RESOLVED calls for partnering with an unknown organization. There are at least three issues identified in the many WHEREAS statements that are best divided into three separate resolutions.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Student Osteopathic Medical Association)*

DATE: **October 14, 2020**

SUBJECT: ADVERSE CHILDHOOD EXPERIENCES SCREENING

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, Adverse Childhood Experiences (ACEs) are cumulative potentially traumatic events that occur in childhood (0-17 years), including experiencing or witnessing violence in the home or community, having a family member attempt or die by suicide, or growing up in a household with substance misuse, mental health problems, or instability due to parental separation or household members being in jail or prison[1]; and

WHEREAS, the ACEs can be accurately scored on a validated screening instrument in the primary care setting[2]; and

WHEREAS, the ACEs score has been recognized as a strong predictor of both medical and physical health outcomes, including but not limited to: risks of injury, sexually transmitted infections, maternal and child health problems, teen pregnancy, involvement in sex trafficking, and a wide range of chronic diseases, education and job opportunity losses, and leading causes of death[1, 3-6]; and

WHEREAS, as of January 1, 2020, per the Surgeon General of California, Dr. Nadine Burke Harris, the ACEs Aware Initiative in California has begun funding providers for ACEs Screening to improve public health and address the state's estimated $112.5 billion per year cost in health care expenditures and disease burden as a result of ACEs-related premature death and years of productive life lost to disability[2]; and

WHEREAS, preventing ACEs could potentially reduce many health conditions with economic and social costs to families, communities, and society of hundreds of billions of dollars each year[7]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) **ENCOURAGES** ~~**support and advocate for**~~ the inclusion of Adverse Childhood Experiences (ACEs) screenings in primary care settings.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

References

1. National Center for Injury Prevention and Control. Preventing Adverse Childhood Experiences. cdc.gov. https://www.cdc.gov/violenceprevention/childabuseandneglect/aces/fastfact.html. Published December 31, 2019. Accessed February 10, 2020.
2. Miller TR, Waehrer GM, Oh DL, et al. Adult health burden and costs in California during 2013 associated with prior adverse childhood experiences. *PLOS ONE*. 2020;15(1):e0228019. doi:10.1371/journal.pone.0228019

3. American Academy of Family Physicians. Adverse Childhood Experiences. cdc.gov. https://www.aafp.org/about/policies/all/adversechildhood-experiences.html. Published April 2, 2019. Accessed February 10, 2020.
4. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245-258. doi:10.1016/s0749-3797(98)00017-8
5. Portwood S. Adverse childhood experiences: Current research and practice applications. https://www.apa.org. https://www.apa.org/pi/families/resources/newsletter/2018/11/adverse-experiences. Accessed February 10, 2020.
6. American Academy of Pediatrics. ACEs and Toxic Stress. AAP.org. http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/ACEs-and-Toxic-Stress.aspx. Published 2020. Accessed February 10, 2020.
7. National Center for Injury Prevention and Control. Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. 2019.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: INCLUSION OF PATIENT EDUCATION ON ORGAN DONATION AS A COMPONENT OF A PRIMARY CARE VISIT

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, there are more than 110,000 patients are on the waiting list in need of a life-saving organ transplantation in the United States[1,2]; and

WHEREAS, an average of 20 patients die each day while waiting for a transplant due to a shortage of donated organs[3]; and

WHEREAS, in 2008, children, especially those under 5 years of age, had the highest death rate on the transplant waiting list compared to any other age range[4]; and

WHEREAS, the number of pediatric deceased donors continued to decline and majority of pediatric donors less than 18 years of age are allocated to adults[4]; and

WHEREAS, liver and kidney disease kill over 120,000 individuals each year, which is more people than Alzheimer's, breast cancer, or prostate cancer[3]; and

WHEREAS, in 2019, 83.7% of patients on the waiting list were waiting for a kidney and 11.6% of patients were waiting on a liver donation[5]; and

WHEREAS, 95% of adults support organ donation but only 58% are actually registered as organ donors[5]; and

WHEREAS, every ten minutes, someone is added to the national transplant waiting list, contributing to the persistent gap between the supply and demand of organs[5]; and

WHEREAS, "currently, there are limited programs educating the population about organ donation in the United States resulting in a situation in which the public lacks basic knowledge and understanding of organ donation, i.e. the dire need, living vs. deceased, which organs can be donated during one's lifetime, the time, effort and risk involved"[3]; and

WHEREAS, education provided by United States federal government organizations, including the national DMV website, does not sufficiently educate the public on organ donation facts, myths, and resources[6]; and

WHEREAS, American Osteopathic Association (AOA) Policy H411-A/16 states that the AOA "will develop and continue to promote physician and public education programs to advance the cause of organ and tissue donation and transplantation," and "urges the Osteopathic Family" to not only volunteer personally as organ and tissue donors, but also to "actively encourage their patients to do the same"; and

WHEREAS, a Quality Improvement (QI) study, in which patients were provided an organ donation pamphlet and registration form, performed by the University of Toronto at a primary care clinic showed an overall 18.3% increase in successful organ donor registrations[7]; and

WHEREAS, a study of 300 patients showed that 40% of the participants who were previously not organ donors committed to becoming organ donors after receiving a verbal or written intervention that shared information regarding organ donations during a visit at a family practice medical center. The data from this study suggests that "the family physician-patient encounter is an excellent opportunity for educating patients and increasing the commitment to organ donation[8]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) adopts an official position supporting organ donation counseling during a visit with a new primary care physician at the provider's discretion as a means of educating and encouraging patients to become organ donors in order to ameliorate the national organ shortage.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

References

1. U.S. Department of Health and Human Services, Health Resources and Services Administration (2018). Organ Procurement and Transplantation. Retrieved from https://optn.transplant.hrsa.gov/
2. United Network for Organ Sharing (2018). Retrieved from https://unos.org/data/
3. American Transplant Foundation (2018). Retrieved from https://www.americantransplantfoundation.org/about-transplant/facts-and-myths/
4. McDiarmid, S.V., Cherikh, W.S., Sweet, S.C. Preventable Death: Children on the Transplant Waiting List (2008.)
5. U.S. Department of Health and Human Services, Health Resources and Services Administration (2019). Organ Donation Statistics. Retrieved from https://www.organdonor.gov/statistics-stories/statistics.html
6. DMV.org (2018). Retrieved from https://www.dmv.org/organ-donation-myths.php
7. National Center for Biotechnology Information, Inc. (2018). Increasing Organ Donor Registration in a Primary Care Clinic. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5411726/
8. Bidigare, S. A. (2000). Family Physicians Role in Recruitment of Organ Donors. Archives of Family Medicine, 9(7), 601–605. doi: 10.1001/archfami.9.7.60

Explanatory Statement: Reference Committee

The Committee believes the current policy on file (411-A/16) addresses this issue. In addition, many states already show such information on drivers' licenses.

Background Information: Provided by AOA Staff

Current AOA Policy: H411-A/16 ORGAN AND TISSUE DONATION AND TRANSPLANTATION INITIATIVES – COMMITMENT TO

Prior HOD action on similar or same topic: Policy reaffirmed as amended in 2016.

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: INEQUALITIES IN MEDICAID FUNDING AFFECTING U.S. TERRITORIES

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, Puerto Rico, American Samoa, the Commonwealth of the Northern Mariana Islands (CNMI), Guam, and the U.S. Virgin Islands (USVI) are U.S. territories, which poses the obligation to pay federal taxes[5]; and

WHEREAS, a large proportion of U.S. citizens living on U.S. territories rely on Medicaid or Children's Health Insurance Program (CHIP) to pay for their healthcare, although the total number varies per territory[7]; and

WHEREAS, 79% of U.S. citizens living in American Samoa were enrolled in Medicaid, compared to 37% in Puerto Rico, in 2017[7]; and

WHEREAS, differences in funding between territorial and mainland Medicaid programs can be narrowed down to two key policies: statutory caps on federal funding and the federal Medicaid match rate formula[1,7]; and

WHEREAS, federal funding for mainland Medicaid programs are not capped, therefore every dollar spent is reimbursed by the federal government as long as they are valid under the program's rules[1,7]; and

WHEREAS, federal funding for territorial Medicaid programs are statutorily capped based on Section 1108 of the Social Security Act[7]; and

WHEREAS, U.S. territories receive an allotted amount of funds for Medicaid every year regardless of fluctuations in enrollment or service usage[7]; and

WHEREAS, the federal government does not match territorial Medicaid spending beyond the annual cap, therefore shifting the economic burden to each territory's finances[1,7]; and

WHEREAS, the federal Medicaid match rate (Federal Medical Assistance Percentage, or FMAP) is used for determining the amount of federal matching funds for most Medicaid expenditures[3]; and

WHEREAS, on the mainland, FMAPs vary depending on the state's per capita income, and states with lower per capita incomes have an increased FMAP due to greater economic need[1]; and

WHEREAS, in U.S. territories, the FMAP is a fixed rate and is based on a different formula that does not consider per capita income, in which the statutory FMAP for all U.S. territories is set at 55%, with exception of recent, temporary changes[1,7]; and

WHEREAS, in U.S. territories, the statutory cap on Medicaid funding along with the fixed FMAP has led to budget deficits and the need for frequent infusions of funds to support the programs temporarily[1,7]; and

WHEREAS, territories received a considerable infusion of federal funds for Medicaid under the Patient Protection and Affordable Care Act in 2010[7]; and

WHEREAS, the Balanced Budget Act of 2018 gave Puerto Rico and the USVI further funding for Medicaid at 100% FMAP until September 30, 2019[7]; and

WHEREAS, the Additional Supplemental Appropriations for Disaster Relief Act of 2019 was enacted to provide added funds to CNMI at 100% FMAP through the end of fiscal year 2019, and permitted Guam and American Samoa to use their remaining ACA funds at 100% FMAP during the same period[7]; and

WHEREAS, although it is estimated that all territories will be able to adequately fund their Medicaid and CHIP programs through the end of fiscal year 2019, the added funds that are keeping them viable will expire at the end of this year[7]; and

WHEREAS, estimates show that there will be significant budget deficits in fiscal year 2020 in all five territories once the additional funds have expired[7]; and

WHEREAS, prior to these infusions, territories such as Puerto Rico had substantial shortcomings in federal funding for its Medicaid program[1,7]; and

WHEREAS, the combinatory effect of a low FMAP and the statutory cap creates an estimated effective match rate of approximately 18% in Puerto Rico, a rate usually found in states with a high PCI[2]; and

WHEREAS, for Puerto Rico, it is estimated that if the statutory cap is removed and the territorial FMAP is calculated using the mainland's formula, which reflects per capita income, the effective match rate would increase from 18% to 83%, the maximum allowed under these laws[4,6]; and

WHEREAS, unjustified differences in Medicaid federal funding between Puerto Rico and the mainland has led the island to set limits on medical services typically provided under the mainland program[2]; and

WHEREAS, prior to the recent temporary federal infusions, inadequate funding for the island's Medicaid program led Puerto Rico to take measures that reduce spending by: decreasing the eligibility for Medicaid as compared to mainland criteria, withholding investment in health information technology despite CMS incentives, reducing or suspending provider payments, and excluding benefits from Medicaid coverage, such as long term care[2]; and

WHEREAS, it is estimated that the impending Medicaid budget shortfalls of fiscal year 2020 will drive all five territories to enact changes that reduce costs, such as the aforementioned measures taken by Puerto Rico in the past[7]; and

WHEREAS, the Congressional Task Force on Economic Growth in Puerto Rico warned in 2016 that failure to increase funding for Puerto Rico's Medicaid program would

presumably compel its government to reduce enrollment of low-income individuals, therefore harming their quality of life and spurring outmigration, which can further exacerbate an already critical fiscal crisis[8]; and

WHEREAS, despite differences between territories and the mainland in the amount of federal taxes paid by individuals and businesses, all members of the Congressional Task Force on Economic Growth in Puerto Rico concluded that territories deserved more equitable treatment in Medicaid funding[8]; and

WHEREAS, the Congressional Task Force on Economic Growth in Puerto Rico recommended in 2016 that Congress act swiftly to improve financing for territorial Medicaid programs so that it reflects the size and need of their low-income citizens[8]; and

WHEREAS, the American Osteopathic Association represents a profession that advocates for access to healthcare; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports an increase in or removal of the federal funding cap on territorial Medicaid programs, thereby ~~alleviating~~ **REDUCING** costs and preventing the cost-reducing measures that negatively impact the quality of and access to healthcare of low-income U.S. citizens **AND U.S. NATIONALS** living on the U.S. territories; and, be it further

RESOLVED, that the AOA supports changing the territorial Federal Medical Assistance Percentage formula so that it considers per capita income, thereby tailoring the federal matching rate to each population's financial needs.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

References

1. Perreira, K., Lallemand, N., Napoles, A., & Zuckerman, S. (2017). Environmental Scan of Puerto Rico's Health Care Infrastructure. Retrieved September 21, 2019, from https://www.urban.org/sites/default/files/publication/87016/2001051-environmental-scan-of-puerto-ricos-health-care-infrastructure_1.pdf
2. Perreira, K., Peters, R., Lallemand, N., & Zuckerman, S. (2017). Puerto Rico Health Care Infrastructure Assessment Site Visit Report. Retrieved September 21, 2019, from https://www.urban.org/sites/default/files/publication/87011/2001050-puerto-rico-health-care-infratructure-assessment-site-visit-report_1.pdf
3. Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures. (2017). Retrieved September 21, 2019, from ASPE website: https://aspe.hhs.gov/federal-medical-assistance-percentages-or-federal-financial-participation-state-assistance-expenditures.
4. Sebelius, K. (2013). Report to the President's Task Force on Puerto Rico Status. US Department of Health and Human Services. Retrieved September 22, 2019, from https://obamawhitehouse.archives.gov/sites/default/files/uploads/Puerto_Rico_Task_Force_Exec Summary.pdf

5. Fernández Campbell, A. (2017). Puerto Rico pays taxes. The US is obligated to help it just as much as Texas and Florida. Retrieved September 23, 2019, from Vox website: https://www.vox.com/policy-and-politics/2017/10/4/16385658/puerto-rico-taxes-hurricane
6. Park, E. (2016). Addressing Puerto Rico's Medicaid Funding Shortfalls Would Help Ensure Fiscal Stability and Growth. (2017). Retrieved September 23, 2019, from Center on Budget and Policy Priorities website: https://www.cbpp.org/research/health/addressing-puerto-ricos-medicaid-funding-shortfalls-would-help-ensure-fiscal
7. Schwartz, A. L. (2019). Statement of Anne L. Schwartz, PhD, Executive Director. Retrieved October 2, 2019, from https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Schwartz.pdf.
8. Congressional Task Force on Economic Growth in Puerto Rico. (2016). Retrieved from https://www.finance.senate.gov/imo/media/doc/Bipartisan%20Congressional%20Task%20Force%20on%20Economic%20Growth%20in%20Puerto%20Rico%20Releases%20Final%20Report.pdf

Explanatory Statement: Reference Committee
The addition of "Nationals" to page 3, line 17 will cover citizens of American Samoa.

Background Information: Provided by AOA Staff
Current AOA Policy: H339-A/17 EQUITY IN MEDICARE & MEDICAID PAYMENTS

Prior HOD action on similar or same topic: Policy approved in 2017.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: IMPROVING INSULIN AFFORDABILITY

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, Diabetes Type 1 is one of the most common chronic diseases starting in early childhood in the United States that is fatal without lifelong insulin treatment[1]; and

WHEREAS, over 1.4 million American children and adults are living with Type I diabetes mellitus and 7.4 million Americans with diabetes use one or more formulations of insulin[2]; and

WHEREAS, the number of youth with Type 1 diabetes is projected to increase by 23% in 2050[3]; and

WHEREAS, the researchers who discovered insulin, Richard Banting, J. B. Collip, and Charles Best, sold their patent rights for only $1 each because their goal was to ensure the quality, purity, and potency of insulin sold on the market rather than to profit[4]; and

WHEREAS, the first license to manufacture insulin was granted for humanitarian purposes rather than for profit[5]; and

WHEREAS, counter to the spirit of the initial sale and licensure of insulin, the global insulin market was a $24 million industry in 2014 and will top $48 billion by 2020[6]; and

WHEREAS, the cost of insulin has tripled over a mere decade from 2002-2013, despite only incremental added benefits of new insulin products on the market[7,8,9]; and

WHEREAS, 39% of insulin users reported an increase in the amount they personally pay for insulin in the past year, including 52% of insulin-dependent children[10]; and

WHEREAS, an uninsured person pays up to $480 per vial of insulin, with varying out-of-pocket expenses for insured persons[11]; and

WHEREAS, the out-of-pocket expense for insulin has doubled per prescription[11]; and

WHEREAS, it costs uninsured patients ten times more for insulin treatment at $7,000 annually versus $700 annually with insurance[12]; and

WHEREAS, the diabetes related costs from the Medicare eligible population is expected to skyrocket to $171 billion in 2034, an increase of 380% from 2009[13]; and

WHEREAS, one in four insulin dependent diabetics with associated poor glycemic control reported insulin underuse or rationing due to cost[12,14,15,16]; and

WHEREAS, those who regularly take less insulin than prescribed or miss doses report being forced to choose between affording insulin versus essentials like housing, utilities, transportation, and even other health related purchases, such as doctors visits[10]; and

WHEREAS, one-third of patients with lower incomes who report cost-related insulin underuse also report difficulty affording diabetes equipment, thus increasing the risk for hospitalization[16]; and

WHEREAS, many uninsured and underinsured patients are not only rationing insulin but also resorting to black market purchases of discounted insulin on unregulated classified advertisement websites such as Craigslist[17,18]; and

WHEREAS, diabetics who are forced to ration their insulin have developed preventable complications like diabetic ketoacidosis with some resulting in diabetic coma or death[12,14,15,19]; and

WHEREAS, diabetic ketoacidosis is a complication that could be avoided with adequate insulin treatment, but costs $26,566 per hospitalization, resulting in a healthcare burden of $5.1 billion[2]; and

WHEREAS, an increasing number of patients are dying due to inability to afford insulin with diabetes being the 7th leading cause of death in 2017[2,21]; and

WHEREAS, deaths related to insulin rationing occurs even amongst middle class individuals with health insurance coverage[22,23]; and

WHEREAS, the expansion of Medicaid eligibility in some states addressing gaps in affordable access to diabetes medication and treatment has resulted in a significant increase in insulin prescriptions being filled[22,24]; and

WHEREAS, when primary patents expired in 2015 for Sanofi's Lantus, the world's most widely prescribed insulin and the world's leading drug for Type 1 Diabetics, more than 70 secondary patent applications were filed in an effort to maintain its market monopoly[25,26,27]; and

WHEREAS, market share holding pharmaceutical companies consistently file lawsuits against other companies over plans to produce and sell a generic form of insulin, claiming that patents will be violated and that rights will be infringed upon[25,27]; and

WHEREAS, Eli Lilly agreed to make an 'authorized generic' known as insulin Lispro available for purchase at a 50% price reduction, but a spot check found it was only stocked in 17% of pharmacies across the country in favor of Eli Lilly's 'name brand' drug known as Humalog, which offer a larger, more profitable rebate to insurance companies[28]; and

WHEREAS, cheaper forms of insulin being made available are older formulations or analog insulins that are now rarely prescribed because it takes too long to take effect and then stays in the bloodstream for over 8 hours postprandial, increasing the risk for hypoglycemic events[29]; and

WHEREAS, unbranded biosimilar versions of insulin are projected to be priced at 10-51% less than name brand biologic insulins, with a cost saving potential of between $25 billion to $150 billion over ten years[30,31]; and

WHEREAS, unbranded biosimilar drugs have been available in Europe for years, pharmaceutical companies are distorting safety concerns to delay or prohibit the introduction of biosimilars into the American market[30]; and

WHEREAS, pharmaceutical companies have resorted cutting deals with makers of biosimilars to prevent or delay the entry of lower cost biosimilars into the American market[30,32]; and

WHEREAS, forty-five states and Puerto Rico have enacted laws protecting patients' rights to try a biosimilar drug and protecting the substitution of biosimilar products by pharmacists[33]; and

WHEREAS, two Congressional bills aimed at protecting against industry collusion to keep biosimilars out of the American market and at advancing public awareness and education on biosimilars have had no actions taken since they were introduced in 2019[34,35]; and

WHEREAS, the Food and Drug Administration has set standards for biosimilar drugs that protect against concerns of safety, efficacy, and quality[36]; and

WHEREAS, the Senate Finance Committee Chairman initiated an investigation into the price spikes and high cost of insulin for people with diabetes in January 2019, but the only action taken to date is seeking insulin cost data from the Centers for Medicare and Medicaid Services Administrator[37,38,39];" and

WHEREAS, the Chairman of the House Committee on Oversight and Reform confirmed in January 2019 that "there is a strong bipartisan consensus that we must do something to rein in out-of-control price increases…" by the pharmaceutical industry[40];" and

WHEREAS, two Congressional bills aimed at making insulin affordable have had no actions taken since they were introduced in January and February 2019[41,42]; and

WHEREAS, Colorado and Illinois are the first two states to enact laws that cap insulin co-pays[43,44,45,46]; and

WHEREAS, Virginia recently passed a bill capping insulin copays that is pending their governor's signature into law, which would make it the third state in the country to pass a law capping the cost of insulin and it would be the lowest cap set by any state at $50 per month[47,48]; and

WHEREAS, the bills in Colorado, Illinois, and Virginia only apply to patients who have health insurance coverage and only those who are covered through state-regulated commercial insurance plans[43,44,45,46,47,48]; and

WHEREAS, 28 U.S. Code § 1498 grants the U.S. federal government the right to use or manufacture a patented drug at reasonable compensation to the patent owner[49,50]; and

WHEREAS, 28 U.S. Code § 1498 affords patent owners the right to petition the Court of Federal Claims for compensation, which would allow pharmaceutical companies the ability to seek a reasonable amount while prohibiting them from unilaterally setting predatory market prices on insulin[50,51]; and

WHEREAS, 28 U.S. Code § 1498 was frequently used for crucial drugs in the 1960s and 1970s, including a Department of Defense purchase of an antibiotic directly from a generic manufacturer at 28% of the price charged by the patent holder, Pfizer[49]; and

WHEREAS, the government's use of 28 U.S. Code § 1498 has waned not due to decreased need but due to the increasing strength of the pharmaceutical lobby[49]; and

WHEREAS, Medicare is prohibited from negotiating drug prices due to language inserted into legislation that was written by the pharmaceutical lobby[49,52]; and

WHEREAS, 28 U.S. Code § 1498 provides a reasonable counterweight to Medicare's inability to negotiate drug prices, allowing the government to negotiate prices directly with the manufacturer and function as a free market buyer[49,52,53]; and

WHEREAS, 28 U.S. Code § 1498 continues to be applied today in areas outside of prescription drugs, such as patented methods of hazardous waste clean up, electronic passport technology, and genetically mutated mice in scientific research[49,50]; and

WHEREAS, 28 U.S. Code § 1498 continues to be applied for prescription drugs in cases of extreme need or urgency, such as the anthrax scare in 2001[49]; and

WHEREAS, just the threat of 28 U.S. Code § 1498 from the federal government to purchase a generic version of the antibiotic ciprofloxacin during the anthrax scare in 2001 prompted the patent holder, Bayer, to cut the selling price in half[49,54]; and

WHEREAS, there is growing support of exercising 28 U.S. Code § 1498 to procure Hepatitis C treatment drugs, which have been priced by the patent holder, Gilead, at $80,000 per person for the full course of treatment, earning them $36 billion in just two years, well above the initial cost of research and development[49,50,55,56]; and

WHEREAS, the costs of initial research and development can ultimately amount to as little as 4% of profits[51,53]; and

WHEREAS, the American Osteopathic Association (AOA) enacted H339-A/19 to support increased regulation of pharmacy benefit managers as a way to make life-saving medications, including but not limited to insulin, free for all uninsured patients and fully covered for all insured patients, but has no broader policy directly aimed at insulin cost control; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) support legislation capping insulin copays with every state legislature via their respective state medical societies; and, be it further

RESOLVED, that the AOA support legislation that protects the introduction of biosimilar insulin products into the American market and patient access to biosimilar; and, be it further

RESOLVED, that the AOA support federal enforcement of 28 U.S. Code § 1498 for recent and medically effective short-acting and long-acting forms of insulin to address affordability and accessibility for all diabetic patients, including the uninsured.

Explanatory Statement: Submitted by Author:

While there is bipartisan support for solutions to this issue, attempts at new and comprehensive federal legislation have stalled. There have been recent movements in the right direction from a handful of state legislatures capping the cost of insulin. This is a realistic interim solution for insured individuals and this proposal aims to support the implementation of similar bills in remaining states. The limitation is that these legislations do not benefit uninsured individuals. Therefore, to address insulin affordability more broadly, this proposal seeks legislation that protects the introduction of biosimilars that would foster the market competition in insulin costs. Finally, gaps in insulin affordability is a long-standing, drastic problem that requires a drastic solution. This proposal, rather than seeking a wholly new legislation, seeks enforcement of an existing law that the federal government can invoke at its discretion.

References:

1. Imperatore G., Mayer-Davis E.J., Orchard T.J., & Zhong V.W. (2017). Prevalence and Incidence of Type I Diabetes Among Children and Adults in the United States and Comparison with Non-U.S. Countries. In Cowie C.C., Casagrande S.S., Menke A., Cissell M.A., Eberhardt M.S., Meigs J.B., Gregg E.W., Knowler W.C., Barrett-Connor E., Becker D.J., Brancati F.L., Boyko E.J., Herman W.H., Howard B.V., Narayan K.M.V., Rewers M., Fradkin J.E. (Eds.), *Diabetes in America.* (3rd ed., pp. 2.1-2.17) Bethesda, MD: National Institutes of Health. Retrieved on February 2, 2019, from: https://www.niddk.nih.gov/about-niddk/strategic-plans-reports/diabetes-in-america-3rd-edition.
2. Centers for Disease Control and Prevention. *National Diabetes Statistics Report, 2020*. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2020. Retrieved on February 28, 2020, from https://www.cdc.gov/diabetes/data/statistics/statistics-report.html
3. Imperatore, G., Boyle, J. P., Thompson, T. J., Case, D., Dabelea, D., Hamman, R. F., . . . Standiford, D. (2012). Projections of type 1 and type 2 diabetes burden in the U.S. population aged <20 years through 2050. *Diabetes Care, 35*(12), 2515-2520. doi:https://doi.org/10.2337/dc12-0669
4. Rosenfeld, L. (2002, December). Insulin: Discovery and Controversy. *Clinical Chemistry,* 48(12): 2270-88. Retrieved from: http://clinchem.aaccjnls.org/content/48/12/2270.full#sec-21.
5. Woodfield, J. (2016, February 3). *What is the price of profit? The true cost of insulin in the United States.* Retrieved on February 2, 2019, from: https://www.diabetes.co.uk/in-depth/what-is-the-price-of-profit-the-true-cost-of-insulin-in-the-united-states/
6. Tsai, A. (2016, March). The rising cost of insulin. *Diabetes Forecast,* Retrieved from February 27, 2020, from www.diabetesforecast.org/2016/mar-apr/rising-costs-insulin.html
7. Freed, S. (2016, May 7). *What is the Actual Cost of Insulin for Your Patients?*. Retrieved on February 2, 2019, from: http://www.diabetesincontrol.com/actual-cost-of-insulin-for-your-patients/
8. Hua, X., Carvalho, N., Tew, M., Huang, E. S., Herman, W. H., & Clarke, P. (2016). Expenditures and prices of antihyperglycemic medications in the united states: 2002-2013. *Journal of the American Medical Association, 315*(13), 1400-1402. doi:https://doi:10.1001/jama.2016.0126
9. Silverman, E. (2016, April 5). Insulin prices have skyrocketed, putting drug makers on the defensive. *Stat,* Retrieved on February 2, 2019, from

https://www.statnews.com/pharmalot/2016/04/05/insulin-prices-skyrocketed-putting-drug-makers-defensive/

10. American Diabetes Association. (2018). *Insulin affordability survey, 2018*. Arlington, VA; 2020. Retrieved on February 28, 2020, from http://main.diabetes.org/dorg/PDFs/2018-insulin-affordability-survey.pdf
11. Cefalu, W. T., Dawes, D. E., Gavlak, G., Goldman, D., Herman, W. H., Van Nuys, K., . . . Yatvi, A. L. (2018). Insulin access and AffordabilityWorking group: Conclusions and recommendations. *Diabetes Care, 41*(6), 1299-1311. doi:https://doi.org/10.2337/dci18-0019
12. Johnson, C., Y. (2016, October 31). Why treating diabetes keeps getting more expensive. *Washington Post*. Retrieved on February 2, 2019, from https://www.washingtonpost.com/news/wonk/wp/2016/10/31/why-insulin-prices-have-kept-rising-for-95-years/?utm_term=.17cda82418ca
13. Huang, E. S., Basu, A., O'Grady, M., & Capretta, J. C. (2009). Projecting the future diabetes population size and related costs for the U.S. *Diabetes Care*, *32*(12), 2225–2229. https://doi.org/10.2337/dc09-0459
14. Randall, L., Begovic, J., Hudson, M., Smiley, D., Peng, L., Pitre, N., & Umpierrez, G., Denise. (2011). Recurrent Diabetic Ketoacidosis in Inner-City Minority Patients Behavioral, Socioeconomic, and Psychosocial Factors. *Diabetes Care,* 34(9): 1891-6. https://doi:10.2337/dc11-0701
15. Caffrey, M. (2019). Gathering evidence on insulin rationing: Answers and future questions. *AJMC: Evidence-Based Diabetes Management, September*. Retrieved on February 27, 2020, from https://www.ajmc.com/journals/evidence-based-diabetes-management/2019/september-2019/gathering-evidence-on-insulin-rationing-answers-and-future-questions
16. Herkert, D., Vijayakumar, P., Luo, J., Schwartz, J. I., Rabin, T. L., DeFilippo, E., & Lipska, K. J. (2018). Cost-related insulin underuse among patients with diabetes. *JAMA Intern Med, 179*(1), 112-114. doi: https://doi:10.1001/jamainternmed.2018.5008
17. Carroll, L. (2020, February 17). Unregulated sales of insulin common on craigslist. *Reuters* Retrieved on February 27, 2020, from https://www.reuters.com/article/us-health-medication-black-market/unregulated-sales-of-insulin-common-on-craigslist-idUSKBN20B1M0
18. Ahamed, A., Kullmann, K. C., Frasso, R., & Goldstein, J. N. (2020). Analysis of unregulated sale of life-saving prescription drugs online in the united states. *JAMA Intern Med,* doi: https://doi:10.1001/jamainternmed.2019.7514
19. Popken, B. (2019, November 15). With rise in patients dying from rationing insulin, U.N. tries a new solution. *NBC News* Retrieved on February 27, 2020, from https://www.nbcnews.com/business/business-news/rise-patients-dying-rationing-insulin-u-n-tries-new-solution-n1083816
20. Desai, D., Mehta, D., Mathias, P., Menon, G., & Schubart, U. K. (2018). Health care utilization and burden of diabetic ketoacidosis in the U.S. over the past decade: A nationwide analysis. *Diabetes Care, 41*(8), 1631-1638. doi:https://doi.org/10.2337/dc17-1379
21. Higgs, M.M. (2017, April 5). *The High Price of Insulin is Literally Killing People*. Retrieved on February 2, 2019 from: https://tonic.vice.com/en_us/article/ezwwze/the-high-price-of-insulin-is-literally-killing-people
22. Gordon, S. (August 6th, 2018) *Access to Diabetes Drugs Improved Under Affordable Care Act: Study*, Retrieved on February 2, 2019, from: https://consumer.healthday.com/public-health-information-30/affordable-care-act-obamacare-955/access-to-diabetes-drugs-improved-under-affordable-care-act-study-736519.html
23. Rapaport, L. (2020, March 3). Two in five U.S. diabetics struggle with medical bills. *Reuters.* Retrieved on March 8, 2020, from https://www.reuters.com/article/us-health-diabetes-finances/two-in-five-u-s-diabetics-struggle-with-medical-bills-idUSKBN20Q2YG

24. Myerson, R., Lu, T., Tonnu-Mihara, I., & Huang, E. S. (2018, Medicaid eligibility expansions may address gaps in access to diabetes medications. *Health Affairs, 37* doi:https://doi.org/10.1377/hlthaff.2018.0154
25. Amin, T. (2018, December 7). Patent abuse is driving up drug prices. just look at lantus. *Stat,* Retrieved February 27, 2020, from https://www.statnews.com/2018/12/07/patent-abuse-rising-drug-prices-lantus/
26. Collier R. (2013). Drug patents: the evergreening problem. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, *185*(9), E385–E386. https://doi.org/10.1503/cmaj.109-4466
27. Stempel, J. (2014, July 8). Sanofi sues eli lilly over insulin rival to lantus. *Reuters.* Retrieved February 27, 2020, from https://www.reuters.com/article/us-elililly-sanofi-lawsuit/sanofi-sues-eli-lilly-over-insulin-rival-to-lantus-idUSKBN0FD20720140708
28. Rowland, C. (2019, December 27). Under fire over high prices, eli lilly promised cheaper insulin in 2019. the result has some senators steamed. *Washington Post.* Retrieved on March 1, 2020, from https://www.washingtonpost.com/business/economy/under-fire-over-high-prices-eli-lilly-promised-cheaper-insulin-in-2019-the-result-has-some-senators-steamed/2019/12/26/6c440b44-204e-11ea-86f3-3b5019d451db_story.html
29. Farley, A. (2019, February 19). Drug prices are killing diabetics. 'Walmart insulin' isn't the solution. *Washington Post.* Retrieved on March 8, 2020, from https://www.washingtonpost.com/outlook/2019/02/19/drug-prices-are-killing-diabetics-walmart-insulin-isnt-solution/
30. Rowland, C. (2019, January 9). 'Marketers are having a field day': Patients stuck in corporate fight against generic drugs. *Washington Post* Retrieved on March 8, 2020, from https://www.washingtonpost.com/business/economy/drugmakers-alleged-scare-tactics-may-hold-back-competition/2019/01/09/612ac994-046d-11e9-9122-82e98f91ee6f_story.html
31. Mulcahy, A. W., Hlavka, J. P., & Case, S. R. (2017). Biosimilar cost savings in the united states: Initial experience and future potential. *RAND Corporation,* doi:https://doi.org/10.7249/PE264
32. Mathias, T. (2018, April 5). AbbVie, samsung bioepis in deal; humira biosimilar U.S. release in 2023. *Reuters.* Retrieved on March 8, 2020, from https://www.reuters.com/article/us-abbvie-biogen/abbvie-samsung-bioepis-in-deal-humira-biosimilar-u-s-release-in-2023-idUSKCN1HC1SP
33. Cauchi, R. (2019). *State laws and legislation related to biologic medications and substitution of biosimilars.* Washington, D.C.: National Conference of State Legislatures. Retrieved on March 8, 2020, from https://www.ncsl.org/research/health/state-laws-and-legislation-related-to-biologic-medications-and-substitution-of-biosimilars.aspx
34. Preserve access to affordable generics and biosimilars act, S.64, 116th Congress. Retrieved on March 8, 2020, from https://www.congress.gov/bill/116th-congress/senate-bill/64
35. Advancing education on biosimilars act of 2019, S.1681, 116th Congress. Retrieved on March 8, 2020, from https://www.congress.gov/bill/116th-congress/senate-bill/1681
36. *Biosimilar development, review, and approval.* (2017). U.S. Food & Drug Administration. Retrieved on March 8, 2020, from https://www.fda.gov/drugs/biosimilars/biosimilar-development-review-and-approval
37. Alonso-Zaldivar R. (2019, January 29). *GOP senator pledges insulin probe as Congress holds hearings.* AP News. Retrieved on February 2, 2019, from https://apnews.com/56f383814d124b53a59a8dc044bcbfa1
38. Drug pricing in america: A prescription for change, part I: Commitee on Finance, United States Senate, 116th Congress (2019). Retrieved on March 8, 2020, from https://www.finance.senate.gov/hearings/drug-pricing-in-america-a-prescription-for-change-part-i

39. Committee on Finance. (2019). Grassley, wyden seek insulin cost data from CMS. Retrieved on March 3, 2020, from https://www.finance.senate.gov/chairmans-news/grassley-wyden-seek-insulin-cost-data-from-cms
40. Pear R. (2019, January 29). *On Both Ends of Capitol, Both Parties Warn Big Pharma on Drug Prices*. The New York Times. Retrieved on February 2, 2019, from https://www.nytimes.com/2019/01/29/us/politics/drug-prices-congress.html
41. Insulin Access for All Act, H.R.366, 116th Congress (2019). Retrieved on February 2, 2019, from https://www.congress.gov/bill/116th-congress/house-bill/366
42. Affordable Insulin Act, H.R.1478, 116th Congress (2019), Retrieved on February 28, 2020, from https://www.congress.gov/bill/116th-congress/house-bill/1478/
43. Zdanowicz, C. (2019, May 23). Colorado is the first state to cap skyrocketing insulin co-pays. *CNN*. Retrieved on February 28, 2020, from https://www.cnn.com/2019/05/23/health/colorado-insulin-price-cap-trnd/index.html
44. Reduced insulin prices, HB19-1216, 2019 Regular Session Colorado General Assembly. (2019). Retrieved on February 28, 2020, from https://leg.colorado.gov/bills/hb19-1216
45. Munks, J. (2020, January 24). Saying 'diabetes doesn't discriminate,' gov. J.B. pritzker signs measure limiting out-of-pocket cost of insulin to $100 for 30 day supply. *Chicago Tribune* Retrieved on February 27, 2020, from https://www.chicagotribune.com/politics/ct-insulin-cap-bill-signing-20200124-i4ryr72utra37j4mipmbqr2aiu-story.html
46. Pricing-prescription insulin, SB0667, 101st Session Illinois General Assembly. (2010). Retrieved on February 28, 2020, from http://www.ilga.gov/legislation/BillStatus.asp?GA=101&DocTypeID=SB&DocNum=667&GAID=15&SessionID=108&LegID=116604#actions
47. Seipel, B. (2020, March 6). Virginia lawmakers pass lowest insulin price cap in nation at $50 a month. *The Hill*. Retrieved on March 7, 2020, from https://thehill.com/policy/healthcare/486419-virginia-lawmakers-pass-lowest-insulin-price-cap-in-nation-at-50-a-month?fbclid=IwAR0XGI3fkNNGSPxZmS4FZvX2SKYaLoSSYoe9Gl8d6Hc_rRTtRnyc-wCs6iE
48. Health insurance; cost-sharing payments for prescription insulin drugs, HB66, 2020 Virginia General Assembly. (2020). Retrieved on March 8, 2020, from https://lis.virginia.gov/cgi-bin/legp604.exe?201+sum+HB66
49. Dodge, J. (2017). *The government can legally commandeer drug patents*. The People's Policy Project. Retrieved on March 8, 2020, from https://www.peoplespolicyproject.org/2017/10/02/the-government-can-legally-commandeer-drug-patents/
50. 28 U.S. code § 1498. patent and copyright cases (1948). Retrieved on March 8, 2020, from https://www.govinfo.gov/app/details/USCODE-2011-title28/USCODE-2011-title28-front/context
51. Brennan, H., Kapczynski, A., Monahan, C. H., & Rizvi, Z. (2017). A prescription for excessive drug pricing: Leveraging government patent use for health. *Yale Journal of Law & Technology, 18*(1). Retrieved on February 28, 2020, from https://digitalcommons.law.yale.edu/yjolt/vol18/iss1/7/
52. Lee, T. T., Gluck, A. R., & Curfman, G. D. (2016). The politics of medicare and drug-price negotiation (updated). *Health Affairs*. Retrieved on March 8, 2020, from https://www.healthaffairs.org/do/10.1377/hblog20160919.056632/full/
53. Kapczynski, A., & Kesselheim, A. S. (2016). 'Government patent use': A legal approach to reducing drug spending. *Health Affairs, 35*(5), 791-797. doi:https://doi.org/10.1377/hlthaff.2015.1120
54. Bradsher, K., & Andrews, E. L. (2001, October 24). A nation challenged: Cipro; U.S. says bayer will cut cost of its anthrax drug. *New York Times*, Section B, pp.7. Retrieved on March 8, 2020, from https://www.nytimes.com/2001/10/24/business/a-nation-challenged-cipro-us-says-bayer-will-cut-cost-of-its-anthrax-drug.html

55. Tribble, S. J. (2017, May 4). Louisiana proposes tapping A federal law to slash hepatitis C drug prices. *Kaiser Health News* Retrieved on March 8, 2020, from https://khn.org/news/louisiana-proposes-tapping-a-federal-law-to-slash-hepatitis-c-drug-prices/
56. 56. Gee, R. E. (2017). *Hepatitis C in louisiana is increasing and an important health equity issue.* Baton Rouge, LA: Louisiana Department of Health. Retrieved on March 8, 2020, from https://khn.org/wp-content/uploads/sites/2/2017/04/gee-letter-4_12_17.pdf

Explanatory Statement: Reference Committee
With the numerous WHEREAS statements, the intent of resolution needs to be clarified. There are multiple issues covered that should be separated into separate resolutions.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Student Osteopathic Medical Association)*

DATE: **October 14, 2020**

SUBJECT: MEDICATION FOR OPIOID USE DISORDER INSURANCE COVERAGE

SUBMITTED BY: American Osteopathic Academy of Addiction Medicine

REFERRED TO: Committee on Professional Affairs

WHEREAS, the American Osteopathic Association has previously resolved to "remove any arbitrary and restrictive limits for buprenorphine insurance coverage" (H336-A/15) for the treatment of Opioid Use Disorder (OUD); and

WHEREAS, only 29.9% of patients with OUD received evidence-based Medication for Opioid Use Disorder (MOUD) treatment in 2017; and

WHEREAS, prior authorization is a burdensome process that impedes upon the physician-patient relationship, often in an arbitrary and non-evidence-based manner; and

WHEREAS, failure to expeditiously begin MOUD treatment, or an interruption in therapy, can cause devastating consequences for patients, families, and communities, including preventable deaths; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) will explicitly advise the Center for Medicare and Medicaid Services (CMS) and commercial insurers to remove prior authorization restrictions for Medication for Opioid Use Disorder (MOUD); and, be it further

RESOLVED, that the AOA strongly encourage the American Osteopathic Academy of Addiction Medicine (AOAAM) to maintain the above position.

Explanatory Statement: Submitted by Author:

In 2017 overdose deaths due to opioids once again constituted the highest single cause of accidental deaths in the United States. Various buprenorphine preparations, including long-acting injectable buprenorphine, have been shown to be very effective as reducing deaths and decreasing illicit opioid use, but burden prior authorization requirements often render physicians and other providers unable to optimize treatment. Given the various tolerance and efficacy patients experience with regard to various buprenorphine preparations, every effort should be made to limit or eliminate prior authorization, as even a slight delay in treatment or interruption of therapy can be deadly.

Explanatory Statement: Reference Committee

The Committee believes the current policy on file (336-A/15) addresses this issue.

H336-A/15 BUPRENORPHINE MAINTENANCE TREATMENT INSURANCE COVERAGE

The American Osteopathic Association (AOA) recommends that state Medicaid administrators remove any arbitrary and restrictive limits for buprenorphine coverage and that state Medicaid administrators and third party payers recognize that chronic disease management includes a combination of psychotherapeutic and pharmacological interventions that will yield the best outcomes for patients with opioid use disorder. 2015

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: RECRUITMENT AND RETENTION OF NATIVE AMERICANS IN MEDICINE

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, there are approximately 5.2 million American Indian/Alaska Native (AI-AN) people in the United States, including those of more than one race; 1.7% of the population[1]; and

WHEREAS, there are currently 95 (0.3%) students of AI-AN ethnicity enrolled in osteopathic medical schools and 3,400 (0.4%) AI-AN physicians practicing in the United States[2]; and

WHEREAS, the AI-AN population has an average life expectancy that is 5.5 years less than that of the United States population, and has higher mortality rates in many categories, including: heart disease, malignant neoplasm, chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases[3]; and

WHEREAS, research indicates that physician-patient racial and ethnic concordance leads to patients perceiving a higher quality of care, increased use of care, and higher satisfactory rating of care[4]; and

WHEREAS, AI-AN physicians are more likely to practice in Native communities[5]; and

WHEREAS, there have been instances of medical schools succeeding in enrolling higher average numbers of AI-AN students by integrating social and cultural aspects into their institutions and engaging the tribal nations and communities by setting up educational pathway programs in these areas[6]; and

WHEREAS, the Association of Native American Medical Students (ANAMS) is a student organization representing Native American graduate health professional students that supports and provides a resource network with the goal of increasing the number of Native American students in medicine and the successful completion of their graduate health professions curricula[7]; and

WHEREAS, the Student Osteopathic Medical Association (SOMA) has made it a priority to recruit underrepresented minorities in medicine through the National Outreach for Diversity (NOD) programming and through advocating for the improvement of accreditation standards on diversity at Osteopathic medical schools outlined in Policy S-19-23[8]; and

WHEREAS, existing American Osteopathic Association policy H433-A/15 (Minority Health Disparities) states for action to be taken for the development of strategies to actively recruit underrepresented minority physicians into the profession in both primary care

and subspecialties, but does not mention retaining minority physicians[9]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) work with various stakeholders (including the Student Osteopathic Medical Association and the Association of Native American Medical Students) to establish best practices to increase the number of Native Americans recruited and retained in medicine and the allied professions.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

References

1. The American Indian and Alaska Native Population: 2010 Census Briefs. (2012). United States Census Bureau, 2010. Retrieved from https://www.census.gov/history/pdf/c2010br-10-112019.pdf
2. Study of Declining Native American Medical Student Enrollment. (2018). AMA Council on Medical Education Report.
3. Indian Health Disparities from 2009-2011. (2019). Indian Health Service. Retrieved from https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/Disparities.pdf
4. Saha, S., Komaromy, M., Koepsell, T. and Bindman, A. (1999). Patient-Physician Racial Concordance and the Perceived Quality and Use of Health Care. Archives of Internal Medicine , [online] 159(9), p.997. Available at: https://www.ncbi.nlm.nih.gov/pubmed/10326942
5. Analyzing Physician Workforce Racial and Ethnic Composition Associations: Physician Specialties. (2014). Association of American Medical Colleges. Retrieved from https://www.aamc.org/system/files/d/1/444068-aibphysicianworkforce.pdf
6. Reshaping the Journey. (2018). Association of American Medical Colleges. Retrieved from https://store.aamc.org/downloadable/download/sample/sample_id/243/
7. Association of Native American Medical Students. (2020). Retrieved from http://www.anamstudents.org
8. SOMA Resolution S-19-23 http://policysearch.wpengine.com/wp-content/uploads/S-19-23.pdf
9. MINORITY HEALTH DISPARITIES. (2015). American Osteopathic Association, H433-A/15. Retrieved from http://policysearch.wpengine.com/wp-content/uploads/H433-A2015-MINORITY-HEALTH-DISPARITIES.pdf

Explanatory Statement: Reference Committee

The Committee believes the American Osteopathic Association should be supportive and inclusive of all minorities who pursue a career in the osteopathic medicine, and not just one. Support and inclusion of all minorities is currently covered under existing AOA policy, as was noted in the resolution.

Background Information: Provided by AOA Staff

Current AOA Policy:

H429-A/14 MINORITIES, UNDERREPRESENTED (URM) -- INCREASING NUMBERS OF APPLICANTS, GRADUATES AND FACULTY AT COLLEGES OF OSTEOPATHIC MEDICINE

H409-A/16 MINORITY HEALTH AND OSTEOPATHIC MEDICAL EDUCATION

Prior HOD action on similar or same topic: H429-A/14 policy approved in 2014 (Referred to BOE and BSAPH in 2019). H409-A/16 policy reaffirmed in 2016.

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: SUSTAINABILITY AT AOA EVENTS

SUBMITTED BY: Maine Osteopathic Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, there is agreement within the scientific community that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant; and

WHEREAS, large in person events can generate significant waste and be harmful to the environment; and

WHEREAS, the American Osteopathic Association (AOA) has traditionally held at minimum three events of over two hundred people per year; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) will make efforts to make events "green" and sustainable such as: choosing eco-friendly venues (IACC Green Star certified, i.e.), using compostable or reusable cups and glasses, fabric napkins, going paperless, limiting food waste, reducing transportation footprints, choosing virtual meeting options as appropriate, etc.; and, be it further

RESOLVED, that the AOA will report to the House of Delegates annually on these improvements, starting in 2021.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
Based on Finance Committee's estimate, the Committee believes the costs to implement is prohibitive and could result in a negative fiscal impact. In times of a pandemic, there is potential that use of reusable items could contribute to spread.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $250,000 in additional expenses annually.
The staff estimates that providing sustainable options regarding cups, plates, utensils, etc. for meals and breaks at AOA sponsored events would cost an addition $250,000 annually. Presently, due to COVID-19 venues are not offering or providing a sustainable option; additionally, virtual meetings are the current option for the foreseeable future, therefore under these circumstances a direct fiscal impact cannot be accurately determined at this time.

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H357-A/19 NUTRITION AND LEADING BY EXAMPLE

SUBMITTED BY: Osteopathic Physicians and Surgeons of Oregon

REFERRED TO: Committee on Professional Affairs

WHEREAS, at the 2018 American Osteopathic Association (AOA) House of Delegates, resolution H-365 was approved resolving that the AOA consider meal nutritional content when planning events; and

WHEREAS, the preponderance of evidence shows negative health outcomes associated with the consumption of sugar sweetened beverages and processed meats and;

WHEREAS, the World Health Organization, International Agency for Research on Cancer has classified processed meat as carcinogenic to humans (Group 1); and

WHEREAS, nudges, defined as a subtle environment cues designed to make healthy food choices the easy choice have been shown to increase consumption of healthy foods; and

WHEREAS, the AOA has the opportunity to lead by example - recognizing the impact that nutrition has on human health when providing meals; and

RESOLVED, that sugar sweetened beverages and processed meats be excluded from all American Osteopathic Association (AOA) sponsored events where a meal is served; and, be it further

RESOLVED, that the AOA encourage osteopathic medical schools, residency programs, and hospitals to offer plant-based meals and eliminate sugar sweetened beverages and processed meats when meals are served.

Explanatory Statement: Submitted by Finance Committee.
The staff determined an additional annual cost for breakfast, lunch and breaks of $135,000 in Food & Beverage expenses. This would only be incurred if offsets were not taken from other components of the Food & Beverage order for events. However, as meeting staff will strictly remain within their overall individual event budgets, the appropriate reductions would be made in other areas to offset the increased expenses associated with the "healthier" menu options thus no direct fiscal impact. The Committee recognizes that there could be an indirect fiscal impact that cannot be predicted.

Explanatory Statement: Reference Committee
Based on Finance Committee's estimate, the Committee believes the costs to implement is prohibitive and could result in a negative fiscal impact.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H324-A/14 USE OF THE TERM "PHYSICIAN" "DOCTOR" AND "PROVIDER"

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED AS AMENDED.

H324-A/14 USE OF THE TERM "PHYSICIAN" "DOCTOR" AND "PROVIDER"

The American Osteopathic Association (AOA) adopts as policy: (1) that AOA members are encouraged to use the terms "physician" or **"**doctor**"** to describe themselves, leaving other terms such as "practitioner," "clinician," or "provider" to be used by non-physician clinicians or to categorize health care professionals as a whole; (2) supports the appropriate use of credentials and professional degrees in advertisements; (3) SUPPORTS providing a mechanism for physicians to report advertisements related to medical care that are false or deceptive; (4) opposes non-physician clinicians' use of the title "physician," AS WELL AS USE OF THE TITLE~~or~~ "doctor" WITHOUT SPECIFYING THE TYPE OF DOCTORATE RECEIVED, because such communication is likely to ~~deceive~~ CONFUSE the public by implying that the non-physician clinician is engaged in the unlimited practice of medicine; (5) opposes legislation that would expand the use of the term "physician" to persons other than US-trained DOs, and MDs; AND (6) supports a policy that physicians and non-physician clinicians SHOULD identify themselves to their patients ~~noting~~ USING their degree in both a verbal ~~description~~ INTRODUCTION as well as BY~~a~~ OTHER IDENTIFICATION CLEARLY VISIBLE DURING PATIENT ENCOUNTERS ~~visual identification by use of a nametag; (7) will not support legislation, which would allow non-physician clinicians to be called "physician;" (8) supports a policy reserving the title "physician" for US-trained DOs, and MDs who have established the integrity of their education, training, examination and regulations for the unlimited practice of medicine; and (9) opposes the misuse of the title "doctor" by non-physician clinicians, in all communications and clinical settings because such use deceives the public by implying the non-physician clinician's education, training or credentialing is equivalent to a DO or MD~~. 2009; reaffirmed as amended 2014

Explanatory Statement: Submitted by Author

Per the directive of the 2019 AOA House of Delegates, the BSGA convened a workgroup to discuss updates to this policy, specifically regarding use of the term "doctor" by non-DOs/MDs. The amended policy takes into account the fact that many types of healthcare professionals now undergo additional years of education and training in pursuit of a doctorate, and as of 2015, the doctorate is now the qualifying degree for physical therapists. Beginning in 2027, a doctorate will be required of occupational therapists as well. The revised policy balances patient safety by ensuring that patients are aware of who is providing their care, while appropriately recognizing doctoral degrees earned by non-physicians. In addition, the term "provider" is still commonly used among healthcare and governmental organizations to refer to healthcare professionals (including physicians) as a whole, and the revised policy reflects that fact.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN — UNITED STATES, 2016

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, WHEREAS, in 2016 the United States Centers for Disease Control and Prevention (CDC) released its *"Guideline for Prescribing Opioids for Chronic Pain — United States, 2016"* [1] (Guidelines); and

WHEREAS, following its release, many legislatures and regulatory bodies adopted the Guidelines as standards of practice, enacted rules, and have taken action against prescribers who failed to rigidly follow the guidelines; and

WHEREAS these actions led the CDC to issue a statement warning against the misapplication of the Guideline [2]; and

WHEREAS in an article published in the New England Journal of Medicine, Deborah Dowell, MD, MPH, Chief Medical Officer, National Center for Injury Prevention and Control further stated, "*Unfortunately, some policies and practices purportedly derived from the guideline have in fact been inconsistent with, and often go beyond, its recommendations. A consensus panel has highlighted these inconsistencies, which include inflexible application of recommended dosage and duration thresholds and policies that encourage hard limits and abrupt tapering of drug dosages, resulting in sudden opioid discontinuation or dismissal of patients from a physician's practice*." [3]; and

WHEREAS the misapplication of the Guidelines has a high potential for patient harm and may impose needless suffering on patients and bring unwarranted sanctions against physicians; and

WHEREAS through its participation in the American Medical Association's Opioid Task Force, the American Osteopathic Association (AOA) has developed and published recommendations [4] to assist physicians in reversing the opioid epidemic in the US; now, therefore be it

RESOLVED, the American Osteopathic Association (AOA) opposes the misuse and inflexible application of the United States Centers for Disease Control and Prevention (CDC) ~~released its~~ "Guideline for Prescribing Opioids for Chronic Pain — United States, 2016, (Guidelines) by law makers and regulators; and be it further,

RESOLVED the AOA opposes the codification of the Guidelines into law or regulation and their use as a measure of the appropriateness of physicians prescribing; and be it further

RESOLVED the AOA recommends physicians read and consider the use of the 2019 AMA Opioid Task Force 2019 Guidelines[4] **4** in patients being treated for non-malignant chronic pain conditions.

Explanatory Statement: Submitted by Author
2019 AMA Opioid Task Force 2019 Guidelines attached

References

1. Deborah Dowell, MD, CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016, MMWR 65(1);1-49 https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm accessed June 12, 2020
2. CDC Advises Against Misapplication of the Guideline for Prescribing Opioids for Chronic Pain, https://www.cdc.gov/media/releases/2019/s0424-advises-misapplication-guideline-prescribing-opioids.html Accessed June 12, 2020
3. Deborah Dowell, M.D., M.P.H., No Shortcuts to Safer Opioid Prescribing, 2019, N Engl J Med 380:2285-2287, https://www.nejm.org/doi/full/10.1056/NEJMp1904190
4. 2019 Recommendations of the AMA Opioid Task Force, 2019, https://www.end-opioid-epidemic.org/recommendations-for-physicians/, accessed June 12, 2020

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
888.626.9262
osteopathic.org

SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
PUBLIC AFFAIRS - RESOLUTION ROSTER
WITH ACTION

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:

- Committee on Public Affairs (400 series)
  This reference committee reviews and considers matters relating to public and industrial health, research and physical fitness.

Res. No.	Resolution Title	Submitted By	Action
H400	Interference in the Physician-Patient Relationship by Personal Injury Attorneys and Insurance Carrier Agents (H400-15)	BSAPH / BSA	ADOPTED
H401	Osteopathic Name and Identity (H401-A/15)	BOE	ADOPTED *(for sunset)*
H402	Public Education Regarding the Importance and Safety of Vaccines for Infants, Children, and Adults (H402-A/15)	BSAPH	ADOPTED
H403	Support for the Advisory Committee on Immunization Practices (ACIP) Recommendations (H403-A/15)	BSAPH	ADOPTED
H404	Vaccination Rates – Daycare Notification to Parents (H404-A/15)	BSGA	ADOPTED
H405	Protection of Safe Water Supply (H405-A/15)	BFHP / BSAPH	ADOPTED
H406	Antibiotic Stewardship (H407-A/15)	BSAPH	ADOPTED
H407	Vaccines for Children Program (H408-A/15)	BSAPH	ADOPTED
H408	Seat Belt Laws – Primary Enforcement (H409-A/15)	BSGA	ADOPTED
H409	Intrauterine Fetal Demise Awareness (H410-A/15)	BSAPH	ADOPTED
H410	Antifreeze Poisoning (H411-A/15)	BSAPH	NOT ADOPTED
H411	Aircraft Emergency Medical Supplies (H412-A/15)	BFHP	ADOPTED
H412	Animals in Medical Research (H413-A/15)	BSAPH	ADOPTED
H413	Cancer (H415-A/15)	BSAPH	ADOPTED
H414	Cardiopulmonary Resuscitation, Training (H416-A/15)	BSAPH	ADOPTED
H415	Children's Safety Seats (H418-A/15)	BSAPH	ADOPTED
H416	Death – Right to Die (H419-A/15)	BSGA	ADOPTED
H417	Environmental Responsibility--Waste Materials (H420-A/15)	BSAPH	ADOPTED
H418	Firearms and Non-Powdered Guns - Education for Users (H421-A/15)	BFHP	ADOPTED
H419	Genetic Manipulation of Food Products – Consumers Right to Know (H422-A/15)	BSAPH	ADOPTED

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
888.626.9262
osteopathic.org

SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
PUBLIC AFFAIRS - RESOLUTION ROSTER
WITH ACTION

Res. No.	Resolution Title	Submitted By	Action
H420	Condom Usage – Health Education (H423-A/15)	BSAPH	ADOPTED
H421	Support of Literacy Programs (H424-A/15)	BSAPH	ADOPTED
H422	Tanning Devices (H425-A/15)	BSGA	ADOPTED
H423	Tobacco Settlement Funds (H426-A/15)	BSGA	ADOPTED
H424	Healthy Family, Support of (H428-A/15)	BSAPH	ADOPTED
H425	Immunization of 9 to 26 Year Old Male and Females with Human Papilloma Virus Vaccine (H429-A/15)	BSAPH	ADOPTED as AMENDED
H426	Drugs, Curbing Counterfeit (H430-A/15)	BFHP	ADOPTED
H427	Sleep Disorders – Promoting the Understanding and Prevention of (H432-A/15)	BSAPH	ADOPTED
H428	Minority Health Disparities (H433-A/15)	BSAPH	ADOPTED as AMENDED
H429	Infant Walker (Mobile) – Ban on the Manufacture, Sale and Use of (H434-A/15)	BSAPH	ADOPTED
H430	Develop In-Vitro Fertilization Standards of Care (H435-A/15)	BSAPH	ADOPTED as AMENDED
H431	Complementary and Alternative Medicine by Non-Physicians (H436-A/15)	BSGA	REFERRED
H432	Continued Support OF Combating Bio-Terrorism Activities (H437-A/15)	BFHP	ADOPTED as AMENDED
H433	Childhood Obesity – Worsening Epidemic in the American Society (H438-A/15)	BSAPH	ADOPTED
H434	Immunizations – Mainstay of Preventive Medical Practice (H439-A/15)	BSAPH	ADOPTED
H435	Texting While Driving (H440-A/15)	BSAPH	ADOPTED
H436	Silver Alert System (H442-A/15)	BFHP	ADOPTED
H437	National Institutes of Health Grants (H443-A/15)	BFHP	ADOPTED as AMENDED
H438	Screening for Breast Cancer (H444-A/15)	BSAPH	ADOPTED
H439	Gender Identity Non-Discrimination (H445-A/15)	BSAPH	ADOPTED
H440	Traumatic Brain Injury Awareness (H446-A/15)	BSAPH	ADOPTED as AMENDED
H441	Support for Family Caregivers (H448-A/15)	BSAPH	ADOPTED
H442	Firearm Violence (H450-A/15)	BFHP	ADOPTED as AMENDED
H443	Addressing Police Use of Disproportionate Force…	SOMA	REFERRED

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
888.626.9262
osteopathic.org

SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
PUBLIC AFFAIRS - RESOLUTION ROSTER
WITH ACTION

Res. No.	Resolution Title	Submitted By	Action
H444	Adopting and Promoting Non-Stigmatizing Language for Substance Use Disorders	SOMA	ADOPTED
H445	AOA Response to Novel Public Health Threats	MOA	ADOPTED
H446	Background Checks and Firearms Safety Training as a Condition of Firearms Purchase	BFHP	ADOPTED
H447	Fentanyl Testing Strips	AOAAM	ADOPTED as AMENDED
H448	Firearms Policy	BFHP	REFERRED
H449	Homeless Support	OPSC	ADOPTED as AMENDED
H450	Medical Amnesty for Underage Consumption of Alcohol	AOAAM	REFERRED
H451	Opposition to Abstinence-Only Sex Education	SOMA	WITHDRAWN
H452	REFERRED RESOLUTION: Breastfeeding While on Medication Assisted Treatment (MAT)	BSAPH	ADOPTED
H453	REFERRED SUNSET RESOLUTION: H-411 - A/2019: H413-A/14 Epidemic Terrorist Attack Victims, Government Responsibility of Health Care	BFHP	ADOPTED as AMENDED
H454	REFERRED SUNSET RESOLUTION: H429 A/14 Minorities, Underrepresented (URM) – Increasing Numbers of Applicants…	BSAPH	ADOPTED as AMENDED
H455	REFERRED RESOLUTION: Regulation of E-Cigarettes and Nicotine Vaping	BSAPH	ADOPTED as AMENDED
H456	Recognizing Health Care as a Human Right	MOA	NOT ADOPTED
H457	Support a Culture of Patient Safety and Speaking Up from Medical Students and Preceptors in Healthcare Settings	SOMA	WITHDRAWN
H458	WITHDRAWN	IOMA	WITHDRAWN

SUBJECT: H400-A/15 INTERFERENCE IN THE PHYSICIAN-PATIENT RELATIONSHIP BY PERSONAL INJURY ATTORNEYS AND INSURANCE CARRIER AGENTS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health / Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health and Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H400-A/15 INTERFERENCE IN THE PHYSICIAN-PATIENT RELATIONSHIP BY PERSONAL INJURY ATTORNEYS AND INSURANCE CARRIER AGENTS

The American Osteopathic Association opposes any interference in the physician-patient relationship by persons with financial and business interests regarding a personal injury incident. 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H401-A/15 OSTEOPATHIC NAME AND IDENTITY

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be SUNSET.

H401-A/15 OSTEOPATHIC NAME AND IDENTITY
The American Osteopathic Association will advise the Accreditation Council for Graduate Medical Education that MDs who complete osteopathic-recognized residencies should describe themselves as "MDs who have been trained in Osteopathic Manipulative Medicine" and not as Osteopathic Physicians or DOs. 2015.

Explanatory Statement: Submitted by Author
The BOE recommends this policy be sunset because the AOA no longer separately accredits graduate medical education programs.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED** *(for sunset)*

DATE: **October 14, 2020**

SUBJECT: H402-A/15 PUBLIC EDUCATION REGARDING THE IMPORTANCE AND SAFETY OF VACCINES FOR INFANTS, CHILDREN, AND ADULTS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H402-A/15 PUBLIC EDUCATION REGARDING THE IMPORTANCE AND SAFETY OF VACCINES FOR INFANTS, CHILDREN, AND ADULTS

The American Osteopathic Association supports the widespread use and high compliance rate of the Health and Human Services National Vaccine Implementation Plan for infants, children, and adults through education of the public using media and marketing tools available to its organization. 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H403-A/15 SUPPORT FOR THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) RECOMMENDATIONS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H403-A/15 SUPPORT FOR THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) RECOMMENDATIONS

The AOA encourages osteopathic physicians consider the vaccination history as an integral part of their patient's health record and should counsel their patients on appropriate vaccinations for their age and health conditions. Osteopathic physicians should take all reasonable steps to ensure their patients of all ages are fully immunized against vaccine preventable illnesses and make vaccine recommendations to their patients according to the recommendations of the Advisory Committee on Immunization Practices (ACIP) and published in the Morbidity and Mortality Weekly Report (MMWR) and should not advocate alternative schedules. 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H404-A/15 VACCINATION RATES – DAYCARE NOTIFICATION TO PARENTS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H404-A/15 VACCINATION RATES – DAYCARE NOTIFICATION TO PARENTS

The American Osteopathic Association (AOA) supports legislation at the state level that requires daycare facilities to notify parents (in compliance with Health Insurance Portability and Accountability Act (HIPAA) regulations and state regulations where applicable) that their facility has in its care unvaccinated children who may pose a health risk to high risk populations. 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H405-A/15 PROTECTION OF SAFE WATER SUPPLY

SUBMITTED BY: Bureau on Federal Health Programs / Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Federal Health Programs and the Bureau on Scientific Affairs recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H405-A/15 PROTECTION OF SAFE WATER SUPPLY

The American Osteopathic Association (AOA) ~~will~~ encourageS the oil industry and the Environmental Protection Agency (EPA) to seek out new technologies for safer disposal of waste well water and the protection of our water supply. 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H407-A/15 ANTIBIOTIC STEWARDSHIP

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H407-A/15 ANTIBIOTIC STEWARDSHIP
The American Osteopathic Association (AOA), supports the five core actions outlined in the National Strategy for Combating Antibiotic-Resistant Bacteria and calls upon osteopathic physicians to adopt the principles of responsible antibiotic use, or antibiotic stewardship, which is a commitment to ~~always~~ use antibiotics only when they are MEDICALLY necessary ~~to treat, and in some cases prevent, disease; to choose the right antibiotics; and to administer appropriately~~. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H408-A/15 VACCINES FOR CHILDREN PROGRAM

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H408-A/15 VACCINES FOR CHILDREN PROGRAM
The American Osteopathic Association supports the expansion of the Vaccines for Children (VFC) Program to include all Advisory Committee on Immunizations Practices (ACIP) age appropriate vaccines for all underinsured children, in keeping with the original goals of the program. 2005; revised 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H409-A/15 SEAT BELT LAWS – PRIMARY ENFORCEMENT

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H409-A/15 SEAT BELT LAWS – PRIMARY ENFORCEMENT
The American Osteopathic Association ~~endorses~~ SUPPORTS the ~~passage of~~ primary enforcement seat belt laws in every state. 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H410-A/15 INTRAUTERINE FETAL DEMISE AWARENESS

SUBMITTED BY: Bureau on Scientific Affairs and Public Heath

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H410-A/15 INTRAUTERINE FETAL DEMISE AWARENESS
The American Osteopathic Association supports increasing public awareness of the risk for intrauterine fetal demise and encourages the director of the National Institutes of Health to allocate more resources to intrauterine fetal demise research. 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H411-A/15 ANTIFREEZE POISONING

SUBMITTED BY: Bureau on Scientific Affairs and Public Heath

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H411-A/15 ANTIFREEZE POISONING
The American Osteopathic Association supports the addition of a bittering agent to antifreeze to lessen the likelihood of accidental ingestion. 2010; revised 2015.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
The addition of a bittering agent to antifreeze is now the law in all 50 states so this policy is no longer needed.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H412-A/15 AIRCRAFT EMERGENCY MEDICAL SUPPLIES

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H412-A/15 AIRCRAFT EMERGENCY MEDICAL SUPPLIES

The American Osteopathic Association supports the concept that airlines, under the control of the Federal Aviation Administration, maintain a policy for adequately equipping commercial aircraft of greater than 19 seats with at least minimal diagnostic and emergency medical supplies and supports legislation and regulation that any physician providing emergency service while on board aircraft be immune from any liability or legal action. 1984; revised 1989, 1995; reaffirmed 2000, revised 2005, reaffirmed 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H413-A/15 ANIMALS IN MEDICAL RESEARCH

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H413-A/15 ANIMALS IN MEDICAL RESEARCH
The American Osteopathic Association (AOA) supports the use of animals for valid medical research projects and the humane handling and treatment of such animals, and their ready availability from legitimate sources. The AOA supports eventual elimination of the use of animals in medical research as better techniques become available. 1990; reaffirmed 1995; revised 2000, revised 2005; reaffirmed 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H415-A/15 CANCER

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H415-A/15 CANCER

The American Osteopathic Association recognizes, endorses, and approves the continuing efforts of the National Cancer Institute to develop means to significantly reduce the incidence of cancer and the suffering and death resulting from cancer. THE AOA ~~and~~ will disseminate to the medical community and the public ~~it serves~~, information gained from osteopathic and other research activities on the applications of the latest advances in cancer prevention, detection, early diagnosis and treatment. 1974; reaffirmed 1980, 1985; revised 1990, 1995, reaffirmed 2000, revised 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H416-A/15 CARDIOPULMONARY RESUSCITATION, TRAINING

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H416-A/15 CARDIOPULMONARY RESUSCITATION~~,~~ <u>AND AUTOMATED EXTERNAL DEFIBRILLATOR</u> TRAINING

The American Osteopathic Association strongly supports instruction in cardiopulmonary resuscitation (CPR) AND AUTOMATED EXETERNAL DEFIBRILLATOR (AED) TRAINING to the general public; and encourages member physicians to qualify as instructors in basic life support so as to enable them to teach cardiopulmonary resuscitation AND AED courses on a voluntary basis. 1980; revised 1985, 1990, 1995, 2000, reaffirmed 2005, 2010; 2015.

<u>Explanatory Statement: Submitted by Author</u>
None provided.

<u>Background Information: Provided by AOA Staff</u>
Current AOA Policy: None

Prior HOD action on similar or same topic: None

<u>FISCAL IMPACT</u>: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H418-A/15 CHILDREN'S SAFETY SEATS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRM as AMENDED.

(Old language is crossed out and new language is in CAPS)

H418-A/15 CHILDREN'S SAFETY SEATS
The American Osteopathic Association supports the ADIPTION AND enforcement of child safety seat statutes in accordance with the National Highway Traffic Safety Administration Guidelines. 1985; revised 1990; reaffirmed 1995; revised 2000, 2005; revised 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H419-A/15 DEATH - RIGHT TO DIE

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H419-A/15 ~~DEATH - RIGHT TO DIE~~ END OF LIFE
The AOA believes that the decision to withhold or withdraw treatment from a patient whose prognosis is terminal, or when death is imminent, shall be based upon the wishes of the patient or THEIR ~~his/her~~ family or legal representative if the patient lacks capacity to act on THEIR ~~his/her~~ own behalf as mandated by applicable law. 1979; revised 1984, 1989, 1995, 2000, 2005; revised 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H420-A/15 ENVIRONMENTAL RESPONSIBILITY--WASTE MATERIALS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H420-A/15 ENVIRONMENTAL RESPONSIBILITY--WASTE MATERIALS
The American Osteopathic Association supports ~~the~~ recycling ~~of all recyclables~~. 1995; revised 2000, revised 2005; revised 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H421-A/15 FIREARMS AND NON-POWDERED GUNS - EDUCATION FOR USERS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H421-A/15 FIREARMS AND NON-POWDERED GUNS - EDUCATION FOR USERS

The American Osteopathic Association supports education involving firearm and non-powdered guns safety and the inherent risk, benefits and responsibility of ownership. 1990; reaffirmed 1995, 2000, 2005; revised 2010; revised 2015 [Editor's Note: Non-Powdered Guns are defined as: BB, air and pellet guns, expelling a projectile (usually made of metal or hard plastic) through the force **OF COMPRESSED AIR OR GAS, ELECTRICITY,** ~~**of air pressure, CO2 pressure,**~~ or spring action. Non-powder guns are distinguished from firearms, which use gunpowder to generate energy to launch a projectile.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H422-A/15 GENETIC MANIPULATION OF FOOD PRODUCTS – CONSUMERS RIGHT TO KNOW

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H422-A/15 GENETIC MANIPULATION OF FOOD PRODUCTS – CONSUMERS RIGHT TO KNOW

The American Osteopathic Association supports efforts that require clear identification of any genetically manipulated food products so that consumers may be properly informed as they make food choices. 2000, revised 2005, reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H423-A/15 CONDOM USAGE – HEALTH EDUCATION

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H423-A/15 CONDOM USAGE – HEALTH EDUCATION
The American Osteopathic Association supports full disclosure of the risks and benefits of condom usage and the data on condom failure rates and causes of failure, whenever condom usage is taught. 1995; revised 2000, 2005, reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H424-A/15 SUPPORT OF LITERACY PROGRAMS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H424-A/15 SUPPORT OF LITERACY PROGRAMS
The American Osteopathic Association supports programs that promote literacy in the United States. 1990; revised 1995; reaffirmed 2000, revised 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H425-A/15 TANNING DEVICES

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRM as AMENDED.

(Old language is crossed out and new language is in CAPS)

H425-A/15 TANNING DEVICES
The American Osteopathic Association SUPPORTS EDUCATION AND LEGISLATION TO REDUCE THE use of tanning devices EXCEPT WHERE MEDICALLY INDICATED. 1990; revised 1995, 2000, reaffirmed 2005; revised 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H426-A/15 TOBACCO SETTLEMENT FUNDS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRM as AMENDED.

(Old language is crossed out and new language is in CAPS)

H426-A/15 TOBACCO SETTLEMENT FUNDS
The American Osteopathic Association supports the use of the tobacco settlement fund EXCLUSIVELY for health care services, education and research. 2000, revised 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H428-A/15 HEALTHY FAMILY, SUPPORT OF

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H428-A/15 HEALTHY FAMILY, SUPPORT OF

The American Osteopathic Association recommends that their members support healthy families by encouraging families to do the following: (1) try to eat at least one meal per day together, using healthful nutritional guidelines; (2) a set time be spent together as a family to help with school work and include reading to and with children; (3) ENCOURAGING MEDIA-FREE TIME ~~limiting non-educational use of television, computer, texting / telephones and video game to no more than 2 hours per day~~; (4) limiting exposure to violence; and (5) engaging in a healthy lifestyle that includes exercise. 2005; revised 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H429-A/15 IMMUNIZATION OF 9 TO 26 YEAR OLD MALE AND FEMALES WITH HUMAN PAPILLOMA VIRUS VACCINE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H429-A/15 IMMUNIZATION ~~OF 9 TO 26 YEAR OLD MALE AND FEMALES~~ WITH HUMAN PAPILLOMA VIRUS VACCINE

The American Osteopathic Association ~~recommends~~ SUPPORTS EDUCATION AND IMMUNIZATION for Human Papilloma Virus (HPV) ~~immunization for both females and males, 9 – 26 45 years of age~~. 2010; reaffirmed 2015

Explanatory Statement

Overview:

Human Papillomavirus is a human-specific class of sexually transmitted viruses with over 200 types associated with multiple diseases in humans. These include benign conditions such as genital and nongenital warts and malignant conditions such as cervical, anal, oropharyngeal, vaginal, and vulvar cancer(4).There are approximately 33,700 cases of cancer caused by HPV diagnosed annually(1). Furthermore, the incidence of cervical cancer worldwide is predicted to increase by 50% with the current rate of vaccination (3). Risk factors for developing these malignant conditions include exposure to and infection with associated strains of the HPV Virus (4,5). A recombinant vaccine has been developed including 9 strains associated with malignancy, including types 16 and 18 which are responsible for 70-80% of all cases of Cervical Cancer and 90% of Anal Cancer(6). Based on recent data from the CDC and clinical trials (7,8,9), the FDA has recommended that the recombinant vaccine be administered in both women and men until the age of 45(1,2).

Background:

The HPV recombinant vaccines that have been Bivalent, or targeting 2 strains, have been available since 2006. These initial vaccines targeted 2 strains most commonly associated with Cervical Cancer: strains 16 and 18. In 2017, the Gardasil 9 vaccine was released targeting 9 strains of the virus: 6, 11, 16, 18, 31, 33, 45, 52, and 58 (6). Although 2 of these strains (strains 6 and 11) are more likely to be associated with the development of non-cancerous genital and nongenital warts, the link between presence of warts and development of cancerous lesions is currently being studied (5).

The vaccine was recommended to be administered to women and men ages 9-25(2) as evidence demonstrated that the vaccine is most effective in those who have not previously been exposed to the HPV virus (1,8,9).

Since 1999, there has been a decrease in the incidence of HPV related cervical carcinoma by 1.6%, however there has been an increase in HPV related Cancer of the Mouth and Throat, known as Oropharyngeal Squamous Cell Carcinoma by 2.7% in men and 0.8% in women (7). A study conducted in 2016 revealed that there was a decrease in infection rates and development of Cervical Intraepithelial Neoplasia (a precancerous lesions which can develop into Cervical Carcinoma) in women over 25 who had received the HPV recombinant vaccine and had no previous exposure to HPV over a 7 year period (8,9). In 2018, the FDA revised the Prescribing Information for Gardasil to allow the vaccine to be administered to both women and men until the age of 45 if there was no previous history of HPV infection (2).

Recommendations:

Clinical trials (8,9) have proven that the vaccine is just as effective in both Males and Females over the age of 25 who do not have a history of HPV, the policy should be updated in conjunction with the Prescriber Information and the FDA recommendations - any male without a history of HPV associated warts (genital and nongenital) between the ages of 25-45 and any female between the ages of 25-45 with no history of HPV related warts (genital and nongenital) or negative HPV test with Pap Smear be eligible for 9-valent HPV recombinant vaccine if not previously administered.

In conjunction with current guidelines, regular pap smears should include HPV testing for women above the age of 18, extending the age limit in guidelines beyond the age of 26 (1,6,7).

Sources:

1. ACIP Evidence to Recommendations for HPV Vaccine
https://www.cdc.gov/vaccines/acip/recs/grade/HPV-adults-etr.html

2. Gardasil 9 Prescribing Information

https://www.merck.com/product/usa/pi_circulars/g/gardasil_9/gardasil_9_pi.pdf

3. WHO Call to Action to Eradicate Cervical Cancer

https://www.who.int/reproductivehealth/DG_Call-to-Action.pdf?ua=1

4. UpToDate HPV https://www.uptodate.com/contents/human-papillomavirus-infections-epidemiology-and-disease-associations?search=hpv&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

5. Virology of HPV Infections and Link to Cancer

https://www.uptodate.com/contents/virology-of-human-papillomavirus-infections-and-the-link-to-

cancer?search=hpv&source=search_result&selectedTitle=3~150&usage_type=default&display_rank=3

6. HPV Vaccination

https://www.uptodate.com/contents/human-papillomavirus-vaccination?search=hpv&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2

7. Trends in HPV Related Cancers 1999-2015

https://www.cdc.gov/mmwr/volumes/67/wr/mm6733a2.htm?s_cid=mm6733a2_w%20%5Bcdc.gov%5D

8. Efficacy, Safety, and Immunogenicity of HPV 16/18 ASOV-adjuvanted vaccine in women over 25 years

https://www.ncbi.nlm.nih.gov/pubmed?term=27373900

9. FUTURE Trial for HPV Vaccination

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4636904/#S5title

10. AOA 2019 Policy Compendium

https://osteopathic.org/wp-content/uploads/2019-Policy-Compendium.pdf

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H430-A/15 DRUGS, CURBING COUNTERFEIT

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H430-A/15 DRUGS, CURBING COUNTERFEIT
The American Osteopathic Association supports the Food and Drug Administration's (FDA) efforts to educate osteopathic physicians on how to identify counterfeit drugs. 2005; revised 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H432-A/15 SLEEP DISORDERS – PROMOTING THE UNDERSTANDING AND PREVENTION OF

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H432-A/15 SLEEP DISORDERS – PROMOTING THE UNDERSTANDING AND PREVENTION OF

The American Osteopathic Association supports programs that promote education and understanding of sleep and its impact on health and encourages osteopathic physicians to educate their patients about sleep disorders and the importance of sleep and its impact on health. 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H433-A/15 MINORITY HEALTH DISPARITIES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H433-A/15 MINORITY HEALTH DISPARITIES

The American Osteopathic Association adopts the following Position Statement on Minority Health Disparities (2005; reaffirmed 2010; 2015):

POSITION STATEMENT ON MINORITY HEALTH DISPARITIES

The minority healthcare crisis in America stems from a multitude of factors. In particular, healthcare disparities most greatly affect underrepresented minorities, which include African-Americans, Hispanic-Americans, Asian-Americans, Native Americans and Pacific Islanders. In order to effectively create positive change, certain questions must be addressed. These include, but are not limited to**:** Which minorities are most affected by disease-specific illness? Why do these disparities exist? What can be done to eliminate them? Will a concerted effort to increase awareness and education about health-care disparities result in improved delivery of quality healthcare?

There is a need for the osteopathic profession and all of organized medicine to develop strategies which address health care disparities among minorities and prepare culturally competent physicians. Guidance should be offered to educate practicing physicians and trainees to better resolve known disparities and serve diverse populations. Efforts must be made to assure cultural competency and to identify and overcome language and other barriers to delivering health care to minorities.

Healthcare disparities include differences in health coverage, health access and quality of care. Health disparities result in morbidity and mortality experienced by one population group in relation to another.

Cultural competency is a set of academic and personal skills that allow one to understand and appreciate cultural differences among groups. The better a healthcare professional understands a patient's behavior, values and other personal factors, the more likely that patient will receive effective, high quality care.

Racial and ethnic healthcare disparities caused by problems with access to, and utilization of, quality care may be alleviated through improvements in the cultural competency skills of physicians. Healthcare disparities may also be alleviated through effective recruitment of underrepresented minorities into health professions schools.

The Centers for Disease Control, in conjunction with the U.S. Department of Health and Human Services, created an Office of Minority Health in 1985. Through this collaboration, the Racial and Ethnic Approaches to Community Health Act (REACH) was designed to identify

and eliminate disparities in a number of major areas. Disparities in access to care as well as quality of care in these areas result in poorer outcomes for racial and ethnic minorities.

The identified areas of disparity include: 1) infant mortality; 2) breast and cervical cancer screening and malignancy; 3) cardiovascular and cerebrovascular disease; 4) diabetes; 5) **INFECTIOUS DISEASES (I.E., COVID-19, INFLUENZA, HIV/AIDS);** ~~HIV/AIDS;~~ and 6) child and adult immunizations. In addition, serious disparities exist in the provision of care for mental health problems, substance abuse and suicide prevention.

The American Osteopathic Association calls for the following actions to be taken to address minority health disparities and to improve cultural competency of its physician members:

1. ~~The creation of a forum~~ **THE** EDUCATION OF PHYSICIANS **REGARDING** ~~ABOUT to increase physician knowledge on~~ racial and ethnic healthcare needs, including disparities in the areas listed above;
2. ~~The elimination of provider stereotypical beliefs BIASES AMONG HEALTH CARE PROFESSIONALS~~ **THE PROMOTION OF EDUCATION REGARDING IMPLICIT OR EXPLICIT BIASES AMONG HEALTHCARE PROFESSIONALS** that may play a role in clinical decision-making;
3. The evaluation and analysis of medical information which would permit the targeting of populations who are at greatest risk;
4. The identification of new methods to involve physician members in the communities in which they serve;
5. The identification and integration of available resources to better serve minority communities, including houses of worship, schools and local government;
6. The inclusion of cultural competency training throughout the continuum of osteopathic education;
7. The development of strategies to actively recruit underrepresented minority physicians into the profession in both primary care and subspecialties;
8. The development of approaches to encourage all physicians to provide care to underserved minority populations;
9. The adoption of strategies to assist physicians to effectively communicate with their patients, addressing translation and other barriers to patient understanding.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H434-A/15 INFANT WALKER (MOBILE) – BAN ON THE MANUFACTURE, SALE AND USE OF

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H434-A/15 INFANT WALKER (MOBILE) – BAN ON THE MANUFACTURE, SALE AND USE OF

The American Osteopathic Association supports the ban on the manufacture, sale and use of mobile infant walkers; and urges osteopathic physicians to educate parents and other caregivers on the risks associated with the use of these devices. 2003; revised 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author

Infant Walker–Related Injuries in the United States Ariel Sims, Thitphalak Chounthirath, Jingzhen Yang, Nichole L. Hodges and Gary A. Smith Pediatrics October 2018, 142 (4) e20174332; DOI: https://doi.org/10.1542/peds.2017-4332

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H435-A/15 DEVELOP IN-VITRO FERTILIZATION STANDARDS OF CARE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H435-A/15 DEVELOP IN-VITRO FERTILIZATION STANDARDS OF CARE
The American Osteopathic Association supports the appropriate and evidenced based use of in-vitro fertilization in a manner that promotes the health and safety of both the mother and embryo; and supports the ethical guidelines for the practice of in-vitro fertilization ~~set by the American Society of Reproductive medicine~~ that include, but are not limited to, the appropriate number of embryos implanted per patient. 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H436-A/15 COMPLEMENTARY AND ALTERNATIVE MEDICINE BY NON-PHYSICIANS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRM as AMENDED.

(Old language is crossed out and new language is in CAPS)

H436-A/15 COMPLEMENTARY AND ALTERNATIVE MEDICINE ~~BY~~ – CULTURAL SENSITIVITY TO AND AWARENESS OF

The American Osteopathic Association (1) encourages its members to become knowledgeable about complementary and alternative medicine; (2) encourages its members to discuss the use of complementary and alternative medicine with their patients in a respectful and culturally sensitive manner**~~; AND~~** (3) encourages the continued performance of well-designed, evidence-based research on the efficacy and safety of complementary and alternative medicine. ~~; and (4) opposes all attempts to permit non-physicians to gain practice rights or expand their scope of practice to include complementary and alternative medicine practices.~~ **AND (4) OPPOSES ALL ATTEMPTS TO PERMIT NON-DO/MD PHYSICIANS TO GAIN ADDITIONAL PRACTICE RIGHTS OR EXPAND THEIR SCOPE OF PRACTICE TO INCLUDE COMPLEMENTARY AND ALTERNATIVE MEDICINE PRACTICES.** 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
This statement was added back into H431 because AOA should strongly oppose any expansion of scope of practice from non-physicians.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Bureau of Osteopathic Research and Public Health)*

DATE: **October 14, 2020**

SUBJECT: H437-A/15 CONTINUED SUPPORT OF COMBATING BIO-TERRORISM ACTIVITIES

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H437-A/15 CONTINUED SUPPORT OF COMBATING BIO-TERRORISM ACTIVITIES

The American Osteopathic Association ~~recommends the continued~~ supportS ~~of~~ any and all constitutionally legal efforts to prevent and respond to future acts of bio-terrorism in the United States. 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H438-A/15 CHILDHOOD OBESITY – WORSENING EPIDEMIC IN THE AMERICAN SOCIETY

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H438-A/15 CHILDHOOD OBESITY – WORSENING EPIDEMIC IN THE AMERICAN SOCIETY

The American Osteopathic Association ENCOURAGES ~~will makes efforts to educate~~ schools and vending machine suppliers TO INCLUDE ~~of the need of~~ healthy choice snacks IN VENDING MACHINES; and supports the limited use of vending machines in schools to avoid unnecessary caloric intake. 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H439-A/15 IMMUNIZATIONS – MAINSTAY OF PREVENTIVE MEDICAL PRACTICE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H439-A/15 IMMUNIZATIONS – MAINSTAY OF PREVENTIVE MEDICAL PRACTICE

The American Osteopathic Association will create stronger ties with pro-immunization groups within and outside the osteopathic profession; and whenever possible, will assist these pro-immunization groups with appropriate evidence-based information regarding the safety of immunizations and significant positive effects of the proper use of immunizations relative to the overall public safety. 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H440-A/15 TEXTING WHILE DRIVING

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H440-A/15 TEXTING WHILE DRIVING
The American Osteopathic Association supports efforts to educate all drivers concerning the dangers of texting and driving and supports efforts to ban the use of texting while driving. 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H442-A/15 SILVER ALERT SYSTEM

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H442-A/15 SILVER ALERT SYSTEM
The American Osteopathic Association supports the formation of a "Silver Alert" System on a national level to notify communities of missing persons with mental disabilities, particularly seniors with cognitive or developmental impairments. 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H443-A/15 NATIONAL INSTITUTES OF HEALTH GRANTS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H443-A/15 NATIONAL INSTITUTES OF HEALTH (NIH) - GRANTS
The American Osteopathic Association encourages osteopathic physicians, osteopathic medical schools, and their affiliated institutions to pursue NIH funding for biomedical research; and requests that the NIH include osteopathic medical schools in the overall United States medical school funding reports and also to include a category specific to O~~o~~steopathic MANIPULATIVE TREATMENT **(OMT)** IN THE ESTIMATES OF FUNDING FOR VARIOUS RESEARCH, CONDITION, AND DISEASE CATEGORIES (RCDC) ~~among the Research Condition and Disease Categories~~ reported each year to Congress and the American public. 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H444-A/15 SCREENING FOR BREAST CANCER

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H444-A/15 SCREENING FOR BREAST CANCER
The American Osteopathic Association recognizes and promotes the importance of the integrity of the patient-physician relationship and recommends that breast cancer clinical preventive screenings and coverage be individualized to the extent possible for every patient. 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H445-A/15 GENDER IDENTITY NON-DISCRIMINATION

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H445-A/15 GENDER IDENTITY NON-DISCRIMINATION
The American Osteopathic Association supports the provision of adequate and medically necessary treatment for transgender and gender-variant people and opposes discrimination on the basis of gender identity. 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H446-A/15 TRAUMATIC BRAIN INJURY AWARENESS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H446-A/15 TRAUMATIC BRAIN INJURY AWARENESS

The American Osteopathic Association **(AOA)** believes that osteopathic physicians should be aware of and utilize "best practices" when caring for victims of civil or military conflicts, or natural or man-made disasters, including civilians, returning veterans and their families, particularly those with traumatic brain injury (TBI); and the AOA will work in conjunction with state, specialty and regional societies to provide educational programs to advance this goal. 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H448-A/15 SUPPORT FOR FAMILY CAREGIVERS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H448-A/15 SUPPORT FOR FAMILY CAREGIVERS

The American Osteopathic Association, recognizing a growing number of family caregivers have unaddressed needs related to personal health and wellbeing, supports caregivers by participating in the developing public debate regarding health care policy to include family caregivers and encourages its members to gain education in caregiver illnesses, resources in their area and treat and/ refer when appropriate. 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: H450-A/15 FIREARM VIOLENCE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be **~~SUNSET~~ REAFFIRMED**.

(Old language is crossed out and new language is in CAPS)

H450-A/15 FIREARM VIOLENCE

The American Osteopathic Association (AOA) (1) supports the federal government's January 2013 clarification, "that no federal law in any way prohibits doctors or other health care providers from reporting their patients' threats of violence to the authorities, and issuing guidance making clear that the Affordable Care Act does not prevent doctors from talking to patients about gun safety;" (2) supports funding for the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and other research entities to conduct research on firearm violence and to provide recommendations on reducing firearm violence; (3) supports promotion of policies that will increase access to mental health services and for the appropriate coverage of mental health services by public and private health care programs; and (4) encourages enhanced education of gun safety and safe handling of firearms; and (5) approves the attached Policy Statement on Firearm Violence. 2013; revised 2015

AOA Policy Statement – Firearm Violence

The American Osteopathic Association (AOA) is dedicated to preventing violence in our communities, especially the increased prevalence of firearm violence. As physicians, we see first-hand the devastating consequences of violence to victims and their families. The AOA recognizes that laws, regulations, and policies have the potential to decrease the occurrence of violence, especially firearm violence, in our communities. The AOA supports:

Preserving the Ability of Physicians to Educate and Counsel their Patients on Firearm Violence

Preserving the rights of physicians and other health care professionals to counsel patients on prevention, including the prevention of injury or death as a result of firearms is critical. Physicians play an important role in preventing firearm injuries through health screenings, patient counseling, and referral to mental health services. The AOA supports the Administration's January 2013 clarification, "that no federal law in any way prohibits doctors or other health care providers from reporting their patients' threats of violence to the authorities, and issuing guidance making clear that the Affordable Care Act does not prevent doctors from talking to patients about gun safety." We must ensure that no federal or state law hinders, restricts, or criminalizes the patient-physician relationship.

Advancing Research to Reduce Firearm Violence

Advancing research to reduce firearm violence is a public health issue that deserves the allocation of appropriate resources. The AOA supports funding for the Centers for Disease Control (CDC) and Prevention, the National Institutes of Health (NIH), and other research entities to conduct research on firearm violence and to provide recommendations on reducing firearm violence.

Improving Access to Mental Health Services and Resources

Improving access to mental health services and resources is essential to reducing firearm violence. The AOA supports promotion of policies that will increase access to mental health services and for the appropriate coverage of mental health services by public and private health care programs. Access to mental health services and resources for young adults should be a priority. The early identification of diagnosable mental health issues and subsequent treatment is vital to reducing firearm violence.

Explanatory Statement: Submitted by Author
As per H437-A/19 FIREARM VIOLENCE The American Osteopathic Association (AOA) will develop a comprehensive policy which consolidates all current firearm violence policies into a single unified policy and present it for consideration by the 2020 AOA House of Delegates. 2019

Explanatory Statement: Reference Committee
H448/2020 FIREARMS POLICY requires that all firearms policies "should be maintained and taken up for review and reconsideration by the House of Delegates on an individual basis." Therefore, H442 should be reaffirmed.

Background Information: Provided by AOA Staff
Current AOA Policy: H437-A/19 FIREARM VIOLENCE

Prior HOD action on similar or same topic: Policy approved in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: ADDRESSING POLICE USE OF DISPROPORTIONATE FORCE AGAINST AFRICAN AMERICANS AND OTHER MARGINALIZED POPULATIONS AS AN EMERGING NATIONAL PUBLIC HEALTH ISSUE

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, according to the study published April 2019 by The Proceedings of the National Academies of Sciences, in the U.S., police violence is a leading cause of death for minority populations such as African American, American Indian and Alaskan Natives; with African American males having the highest incidence rate, facing a 1 in 1,000-lifetime risk of being killed during a police encounter, which is 2.5 times higher than their white male counterparts[3]; and

WHEREAS, deficiencies in internal policies and training[4], coupled with lack of adherence to force continuum, requiring officers to prevent excessive force and de-escalate encounters, has created a window to limit the accountability of police force, resulting in increased mortality within already marginalized people of color [3,5]; and

WHEREAS, the American Public Health Association (AHPA) passed a policy in 2018 acknowledging the current law enforcement system mediates the physical and psychological violence directed against marginalized populations that results in the disproportionate death, injuries and trauma of these marginalized populations, with these law-enforcement related deaths amounting to 54,754 years of life lost[2]; and

WHEREAS, the AOA approved policy H439-A/16 which states the AOA's support of "the protection of [LGBTQ] individuals from discriminating practices and harassment[1]; and reaffirmation of the equal rights and protections for all patient populations; and

WHEREAS, an AOA policy that specifically acknowledges gun-violence against marginalized populations wound be concordant with the previously approved resolution H630-A/18 resolving that the AOA joins like-minded organizations in the call for congressional legislation that labels gun violence as a national public health issue[1]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) acknowledges the disproportionate use of force by law enforcement against African Americans and other marginalized groups and its physical and mental health effects on communities.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

References

1. AOA Policy Search. (n.d.). Retrieved from https://osteopathic.org/about/leadership/policy-search/.

2. AHPA, (2019, January 29). Addressing Law Enforcement Violence as a Public Health Issue. (n.d.). Retrieved from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence
3. Edwards, F., Lee, H., & Esposito, M. (2019, August 20). Risk of being killed by police use of force in the United States by age, race–ethnicity, and sex. Retrieved from https://www.pnas.org/content/116/34/16793.
4. Jackman, T. (2015, October 15). De-escalation training to reduce police shootings facing mixed reviews at launch. Available at: https://www.washingtonpost.com/local/public-safety/de-escalation-training-to-reduce-police-shootings-facing-mixed-reviews-at-launch/2016/10/14/d6d96c74-9159-11e6-9c85-ac42097b8cc0_story.html
5. Obasogie, O. K., & Newman, Z. (2017, December 18). Police Violence, Use of Force Policies, and Public Health. Retrieved from https://journals.sagepub.com/doi/full/10.1177/0098858817723665

Explanatory Statement: Reference Committee
Refer back to SOMA to rewrite the Resolve statement to include the health implications of this policy.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Student Osteopathic Medical Association)*

DATE: **October 14, 2020**

SUBJECT: ADOPTING AND PROMOTING NON-STIGMATIZING LANGUAGE FOR SUBSTANCE USE DISORDERS

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, in a cross-cultural study on 18 of the most stigmatized conditions across 14 countries, the World Health Organization determined substance use disorder to be the most stigmatized condition in the world[1]; and

WHEREAS, there are 20.8 million people in the United States struggling with a substance use disorder, yet only 10% receive help[2] despite the high prevalence of 14,500 treatment facilities[3] and 100,000 recovery support meetings across the nation[4]; and

WHEREAS, stigma is a commonly cited reason for not seeking treatment and recovery[5]; and

WHEREAS, research shows that stigmatizing language causes clinicians to have more pejorative attitudes and even to recommend punishment instead of treatments for this medical condition[6]; and

WHEREAS, the International Society of Addiction Journal Editors recommends against the use of terminology that can stigmatize people with substance abuse disorders[7]; and

WHEREAS, the Office of National Drug Control Policy issued a memorandum to the Heads of Executive Departments and Agencies about the importance of changing federal terminology related to substance use disorders[8]; and

WHEREAS, the American Osteopathic Association (AOA) has not yet issued a resolution to adopt and education members on the importance of non-stigmatizing language related to substance use disorders; and

WHEREAS, the AOA has shown a commitment to addressing substance use disorders through outreach, education modules[9], and policy efforts[10];

WHEREAS, the AOA's 2019 policy compendium contained the word "abuse" in the context of substance use disorders 36 times throughout the written policies, not including language in citations or organizational names such as the National Institute of Drug Abuse – situations in which this word would have been reasonable[10]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) commit to the use of clinically- accurate, non-stigmatizing, person-first language ("substance use disorder," "recovery," "substance misuse," "positive or negative urine screen," and "person with a substance use disorder") and discourage the use of stigmatizing terminology ("substance abuse," "substance abuser," "addict," "alcoholic," and "clean/dirty") in future

publications, resolutions, and educational materials both in print and online; and, be it further

RESOLVED, that the AOA encourages its members and organizational partners to incorporate clinically-accurate, non-stigmatizing, person first language into their clinical practice.

Explanatory Statement: Submitted by Author

The following bibliography are the citations referenced in WHEREAS statements above.

References

1. Room, R., Rehm, J,, Trotter, R.T., Paglia, A., & Üstün, T.B. (2001). Cross-cultural views on stigma valuation parity and societal attitudes towards disability. Üstün, T.B. (Ed.). Seattle, WA: Hofgrebe & Huber.
2. United States Department of Health and Human Services. (2016). Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC.
3. National Institute on Drug Abuse. (2018). Principles of Drug Abuse Treatment: A Research Based Guide (Third Edition). Washington, DC.
4. Kelly, J.F. (2016, September). Addiction, Stigma, Treatment, Recovery. Talk presented at Massachusetts General Hospital Recovery Month; September 2016; Boston, Massachusetts.
5. Substance Abuse and Mental Health Services Administration. (2018). Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.
6. Kelly, J.F., Westerhoff, C.M. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. International Journal of Drug Policy, 21(3), 202-207.
7. International Society of Addiction Journal Editors website. (2015). Statements and Guidelines: Addiction Terminology. Retrieved October 5, 2019 from http://www.isaje.net/addiction-terminology.html.
8. Botticelli, M.P. Executive Office of the President of the United States. Memorandum to Heads of Executive Departments and Agencies: Changing Federal Terminology Regarding Substance Use and Substance Use Disorders. Washington, DC.
9. American Osteopathic Association website. (n.d.). Preventing Drug and Substance Use Disorders. Retrieved on October 5, 2019 from https://osteopathic.org/practicing-medicine/providing-care/preventing-drug-use-disorders
10. American Osteopathic Association website. (2019, September). American Osteopathic Association Policy Compendium 2019. Retrieved October 5, 2019 from https://osteopathic.org/wp-content/uploads/2019-Policy-Compendium.pdf.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: AOA RESPONSE TO NOVEL PUBLIC HEALTH THREATS

SUBMITTED BY: Maine Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, the United States Center for Disease Control and Prevention has attributed more than two million cases and one hundred and twenty thousand deaths in the U.S. as of June 2020 due to the COVID-19 pandemic, with more than nine million cases and nearly five hundred thousand deaths globally attributed to COVID-19 according to the World Health Organization; and

WHEREAS, more than twenty-eight thousand people were infected during the 2014-2016 Ebola epidemic, with over eleven thousand deaths; and

WHEREAS, healthcare workers may be at a higher risk than the general population for infection to novel public health threats[1]; and

WHEREAS, medical providers around the world have experienced shortages of the equipment needed to properly test for, protect themselves and treat recent infectious disease; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) will continue to serve as a trusted source of information and education for physicians, health professionals and the public relative to urgent, emergent and novel public health threats; and, be it further

RESOLVED, that the AOA will advocate for and support those responding to urgent, emergent and novel public health threats, including all healthcare workers and volunteers; and, be it further

RESOLVED that the AOA will advocate for proactive planning, improved public health infrastructure, disease threat surveillance and evidence-based responses to novel public health threats affecting the U.S. population.

Explanatory Statement: Submitted by Author

The following bibliography is the citation referenced in WHEREAS statements above.

[1] Epidemiology of and Risk Factors for Coronavirus Infection in Health Care Workers: A Living Rapid Review. Ann Intern Med 2020;May 5:[Epub ahead of print]

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: BACKGROUND CHECKS AND FIREARMS SAFETY TRAINING AS A CONDITION OF FIREARMS PURCHASE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

WHEREAS, firearm-related deaths in the United States have increased to a twenty year high[1]; and

WHEREAS, nearly 40,000 people died in 2017 as a result of firearm-related violence, suicides, and accidents in the United States, the highest rate among industrialized countries[2,3]; and

WHEREAS, intentional suicide by discharge of firearms in the United States increased in 2017, totaling 23,854, compared to 22,938 in 2016[4]; and

WHEREAS, firearms are the third-leading cause of death due to injury after poisoning and motor vehicle accidents[5,6]; and

WHEREAS, 109 firearm deaths occur each day due to firearm-related homicides, suicides, and unintentional deaths[7]; and

WHEREAS, firearm-related violence in the United States had a total societal cost of $229 billion in 2015[8]; and

WHEREAS, in 2017, of the 25 million individuals who submitted to a background check to purchase or transfer possession of a firearm, 103,985 were by prohibited purchasers and were blocked from making a purchase[9]; an estimated 6.6 million firearms are sold annually with no background checks[10]; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) recognizes public health data demonstrating the impact of firearms on mortality and wellness in the United States and will support federal legislation requiring comprehensive background checks for all firearm purchases, including sales by gun dealers, sales at gun shows, and online sales for purchase, which does not extend to firearms transfers between family members or firearms attained through inheritance; and, be it further

RESOLVED, that the AOA will support efforts to require firearms safety training, including military or law enforcement training, as a condition to purchase any class of firearms; and be it further

RESOLVED, that H421-A/15 is superseded by this resolution.

Explanatory Statement: Submitted by Author
The intent of this policy is to supplement the following existing policies:
H630-A/18 Comprehensive Gun Violence Reform
H318-A/16 Firearms--Commission Of A Crime While Using A Firearm
H340-A/16 Physician Gag Rules--Opposition To
H450-A/15 Firearm Violence
H424-A/19 Firearm Safety

References
[1] Center for Disease Control and Prevention. WONDER Database. Underlying Cause of Death, 1999 – 2017.
[2] Id.
[3] Grinshteyn E, Hemenway D. Violent Death Rates: The US Compared with Other High-Income OECD Countries, 2010. Am J Med. 2016;129:266-73.
[4] National Vital Statistics Reports Volume 68, Number 9 June 24, 2019 Deaths: Final Data for 2017 Available at: https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_09-508.pdf
[5] Centers for Disease Control and Prevention. Injury Prevention & Control: Data & Statistics (WISQARS). Atlanta, GA: Centers for Disease Control and Prevention; 2014.
[6] Centers for Disease Control and Prevention. Deaths: Final Data for 2016. Atlanta, GA: Centers for Disease Control and Prevention; 2018.
[7] Center for Disease Control and Prevention. WONDER Database. Underlying Cause of Death, 1999 – 2017.
[8] Follman M, Lurie J, Lee J, West J. The True Cost of Gun Violence in America. 15 April 2015.
[9] Federal Bureau of Investigation. National Instant Criminal Background Check System (NICS) Operations. 2017. Accessed at https://www.fbi.gov/file-repository/2017-nics-operations-report.pdf/view
[10] Cook PJ, Ludwig J. Guns in America: National Survey on Private Ownership and Use of Firearms. Washington, DC: U.S. Department of Justice, National Institute of Justice Research in Brief; May 1997.

Background Information: Provided by AOA Staff
Current AOA Policy: H425-A/19 FIREARM SAFETY

Prior HOD action on similar or same topic: Policy reaffirmed as amended n 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: FENTANYL TESTING STRIPS

SUBMITTED BY: American Osteopathic Academy of Addiction Medicine

REFERRED TO: Committee on Public Affairs

WHEREAS, the American Osteopathic Association (AOA) has in place a broad policy supporting harm reduction for people who use drugs (PWUD) and/or patients with Substance Use Disorder (SUD); and

WHEREAS, the AOA makes no specific mention in their harm reduction policy of the benefits of fentanyl testing strips; and

WHEREAS, fentanyl testing strips have been demonstrated to be an inexpensive and effective method of harm reduction; and

WHEREAS, fentanyl testing strips are illegal to possess, often under "drug paraphernalia" statues in various states; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) will ~~**explicitly**~~ support the universal legalization of fentanyl testing strips, both for Public Health initiatives, as well as personal use; and, be it further

RESOLVED, that the AOA strongly encourage the American Osteopathic Academy of Addiction Medicine (AOAAM) to maintain the above position.

Explanatory Statement: Submitted by Author

In 2016 overdose deaths involving illicitly manufactured fentanyl surpassed heroin and prescription opioid deaths in the US; the number grows. Fentanyl test strips may be an effective overdose prevention tool when included with other evidence-based treatments to prevent opioid overdoses.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: FIREARMS POLICY

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

WHEREAS, the AOA House of Delegates adopted H437-A/19, Firearm Violence, which requires the American Osteopathic Association (AOA) to develop a comprehensive policy that consolidates all current firearm violence policies into a single unified policy and present it for consideration by the 2020 AOA House of Delegates; and

WHEREAS, consolidated, unified policies can have the unintended consequence of disrupting continuity of AOA policy; and

WHEREAS, background and history on a given topic can be lost through the consolidation and elimination of multiple policies into a single policy, making additions or changes to future policy more difficult; and

WHEREAS, having a broad array of policies on a given topic allows the AOA to accurately respond to federal and state legislative and regulatory concerns with nuanced and specific policy to reference; and

WHEREAS, the AOA risks having no policy relating to firearm violence should a portion of a single, consolidated policy on firearms be found to be no longer germane in future years; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) will develop a comprehensive white paper, which will include all current AOA policies relating to firearm violence, into a single, unified document which will be presented for review and consideration by the Bureau on Federal Health Policy (BFHP). This unifying white paper will be presented in lieu of a developing a single firearm violence policy resolution; and

RESOLVED, that H437-A/19 is superseded by this resolution; and

RESOLVED, that the AOA House of Delegates adopt the attached white paper which includes all current AOA policies relating to firearm violence.

AOA Policy White Paper – Firearm Policy

Introduction

The American Osteopathic Association (AOA) is dedicated to reducing the impact of violence on health and wellness in our communities, including injury and death that result from firearm violence. As physicians, we see firsthand the consequences of violence to victims and their families. The AOA recognizes that laws, regulations, and policies have the potential to decrease the occurrence of violence, especially firearm violence, in our communities.

Much of the AOA policy is predicated on an understanding of the role of firearms on public health in the United States. According to the Centers for Disease Control and Prevention (CDC), firearm-related deaths in the U.S. have increased to a twenty year high[i]. Additionally, nearly 40,000 people died in 2017 as a result of firearm-related violence, suicides, and accidents in the U.S., the highest rate among industrialized countries[iiiii]. Firearms are also the third-leading cause of death due to injury after poisoning and motor vehicle accidents[ivv]. CDC data also shows that 109 firearm deaths occur each day due to firearm-related homicides, suicides, and unintentional deaths[vi]. Beyond the impact on the health and well-being of Americans, there is an economic impact with gun violence in the U.S. costing $229 billion in 2015[vii].

Background

H437-A/19 FIREARM VIOLENCE was adopted at the 2019 AOA House of Delegates meeting, which states that the *"American Osteopathic Association (AOA) will develop a comprehensive policy which consolidates all current firearm violence policies into a single unified policy and present it for consideration by the 2020 AOA House of Delegates."* This resolution was then referred to the Bureau on Federal Health Policy (BFHP) for development. After consideration of the request, the BFHP came to the conclusion that developing a single unifying policy sets a potentially problematic precedent in which background and history of a topic can be lost, and makes additions or changes to future policy more difficult.

Beyond setting a precedent, if part of the policy in future years is no longer germane, the full resolution could be in jeopardy, potentially effecting any and all related policies, which in this case could impact more than a half-dozen separate policies relating to firearms. Having a broad array of policies on a given topic allows AOA staff to accurately respond to federal and regulatory concerns with nuanced policy to reference.

With these concerns in mind, the BFHP thought it best that the AOA develop a comprehensive white paper, in lieu of a single firearm violence policy resolution, which includes all current AOA policies relating to firearm violence.

This white paper is intended to provide a complete and cohesive representation of current AOA policy relating to firearm violence and safety as of the 2019 AOA House of Delegates. This document is broken down by *Education, Research, and Miscellaneous.*

Policies Preserving the Ability of Physicians to Educate and Counsel their Patients on Firearm Violence

Preserving the rights of physicians and other health care professionals to counsel patients on prevention, including the prevention of injury or death, as a result of firearms is critical. Physicians play

an important role in preventing firearm injuries through health screenings, patient counseling, and referral to mental health services.

Current Resolutions on Firearm Education:

- **H425-A/19 FIREARM SAFETY**

  The American Osteopathic Association (AOA) recommends that when appropriate, physicians ask patients and/or caregivers about the presence of firearms in the home and counsel patients who own firearms about the potential dangers inherent in gun ownership, especially if vulnerable individuals, children and adolescents are present. The AOA recommends strategies such as secure storage and the use of safety locks to eliminate the inappropriate access to firearms by vulnerable individuals, children and adolescents and recommends all physicians to educate families in the safe use and storage of firearms. 1994; revised 1999, 2004; reaffirmed 2009; 2014; reaffirmed as amended 2019

- **H421-A/15 FIREARMS AND NON-POWDERED GUNS – EDUCATION FOR USERS**

  The American Osteopathic Association supports education involving firearm and non-powdered guns safety and the inherent risk, benefits and responsibility of ownership. 1990; reaffirmed 1995, 2000, 2005; revised 2010; revised 2015 ***[Editor's Note: Non-Powdered Guns are defined as: BB, air and pellet guns, expelling a projectile (usually made of metal or hard plastic) through the force of air pressure, CO2 pressure, or spring action. Non-powder guns are distinguished from firearms, which use gunpowder to generate energy to launch a projectile.]***

- **H340-A/16 PHYSICIAN GAG RULES – OPPOSITION TO**

  The American Osteopathic Association (AOA) is opposed to governmental actions and policies that limit the rights of physicians and other health care practitioners to inquire of their patients whether they possess guns and how they are secured in the home or to counsel their patients about the potential dangers of guns in the home and safe practices to attempt to avoid those potential dangers. The AOA opposes any further legislation or initiatives advocating physician gag rules that limit physicians' right to free speech or other rights. 2016

- **H428-A/19 PHYSICIAN-PATIENT RELATIONSHIP AS RELATED TO PROPOSED GUN CONTROL LAWS, PROTECTION OF THE**

  While the American Osteopathic Association supports measures that save the community at large from gun violence, the AOA opposes public policy that mandates reporting of information regarding patients and gun ownership or use of guns except in those cases where there is duty to protect, as established by the Tarasoff ruling, for fear of degrading the valuable trust established in the physician-patient relationship. 2013; reaffirmed 2019

<u>Policies on Advancing Research to Reduce Firearm Violence</u>

Advancing research to reduce firearm violence is a public health issue that deserves the allocation of appropriate resources. The AOA supports funding for the Centers for Disease Control (CDC) and Prevention, the National Institutes of Health (NIH), and other research entities, to conduct research on firearm violence and to provide recommendations on reducing firearm violence.

Current Resolutions on Firearm Research:

- **H450-A/15 FIREARM VIOLENCE**

  The American Osteopathic Association (AOA) (1) supports the federal government's January 2013 clarification, "that no federal law in any way prohibits doctors or other health care providers from reporting their patients' threats of violence to the authorities, and issuing guidance making clear that the Affordable Care Act does not prevent doctors from talking to patients about gun safety;" (2) supports funding for the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and other research entities to conduct research on firearm violence and to provide recommendations on reducing firearm violence; (3) supports promotion of policies that will increase access to mental health services and for the appropriate coverage of mental health services by public and private health care programs; and (4) encourages enhanced education of gun safety and safe handling of firearms; and (5) approves the attached Policy Statement on Firearm Violence. 2013; revised 2015

- **H630-A/18 COMPREHENSIVE GUN VIOLENCE REFORM**

  The American Osteopathic Association joins like-minded organizations in the call for Congressional legislation that:

  1. Labels gun violence as a national public health issue.
  2. Funds appropriate research on gun violence as part of future federal budgets.
  3. Establishes constitutionally appropriate restrictions on the manufacturing and sale, for civilian use, of large-capacity magazines and firearms with features designed to increase their rapid and extended killing capacity. 2018

Current Miscellaneous Resolutions:

- **Safety- H318-A/16 FIREARMS – COMMISSION OF A CRIME WHILE USING A FIREARM**

  The American Osteopathic Association supports the position that persons accused of a crime involving a firearm be prosecuted to the full extent of the law. 1994; revised 1996, 2001; reaffirmed 2006; reaffirmed as amended 2011; reaffirmed 2016

<u>Conclusion</u>

As noted above, the AOA House of Delegates adopted a policy that calls for the identification of all current firearm violence policies in a single document. This paper reflects that policy and highlights wide range of issues addressed in AOA firearm policies, with seven individual policies identified for inclusion in this paper. At least two resolutions (H425-A/19 and H421-A/15) support education and recommend safety precautions for gun owners. One (H340-A/16) opposes any governmental action that would limit the right of physicians to discuss gun owners and safe storage with their patients. Another (H428-A/19) opposes any mandated reporting of patient gun ownership. Two policies (H450-A/15 and H630-A/18) support federal funding for research on firearm violence. H630-A/18 also labels gun violence as a national public health issue and supports federal legislation that would establish constitutionally appropriate restrictions on the manufacturing and sale of certain classes of firearms.

There is a separate and distinct focus in most of these policies, with focus ranging from education, to protecting the rights of physicians, to support for research, and support for certain restrictions on sales.

As such, these policies, as well as any future firearm-related policies, should be maintained and taken up for review and reconsideration by the House of Delegates on an individual basis.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: H437-A/19 FIREARM VIOLENCE

Prior HOD action on similar or same topic: Policy approved in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Bureau on Federal Health Programs)*

DATE: **October 14, 2020**

[i] Center for Disease Control and Prevention. WONDER Database. Underlying Cause of Death, 1999 – 2017.
[ii] Id.
[iii] Grinshteyn E, Hemenway D. Violent Death Rates: The US Compared with Other High-Income OECD Countries, 2010. Am J Med. 2016;129:266-73.
[iv] Centers for Disease Control and Prevention. Injury Prevention & Control: Data & Statistics (WISQARS). Atlanta, GA: Centers for Disease Control and Prevention; 2014.
[v] Centers for Disease Control and Prevention. Deaths: Final Data for 2016. Atlanta, GA: Centers for Disease Control and Prevention; 2018.
[vi] Center for Disease Control and Prevention. WONDER Database. Underlying Cause of Death, 1999 – 2017.
[vii] Follman M, Lurie J, Lee J, West J. The True Cost of Gun Violence in America. 15 April 2015.

SUBJECT: HOMELESS SUPPORT

SUBMITTED BY: Osteopathic Physicians & Surgeons of California

REFERRED TO: Committee on Public Affairs

~~WHEREAS, the state of California has a disproportionate share of homeless in the country; and~~

WHEREAS, many people in the homeless community have experienced social, racial, and economic inequalities that contribute to medical, mental, and alcohol/drug addiction illnesses, which are often left untreated due to lack of access to health care resources; and

WHEREAS, as osteopathic physicians, we are trained in approaching population health and public health holistically, including addressing access to proper nutrition, hydration, thermal protection, shelter, and hygiene; and

~~WHEREAS, the public health and population health issues of the entire homeless population are providing a public health and population hazard to the community at large; and~~

~~WHEREAS, the lack of affordable and available housing for the homeless during and after implementation of comprehensive treatment programs has contributed to the unprecedented rise in the nation's homelessness; and~~

WHEREAS, there are ~~current~~ ONGOING debates regarding cost effective housing programs which MAY include dormitory, group, and individual housing; and

WHEREAS, the lack of a comprehensive state ~~and~~ OR national strategy to address the homeless issues as ~~a~~ comprehensive population health and public health problemS and ~~medical problem~~ has resulted in significant numbers of those affected to have ~~essentially~~ LITTLE OR no medical care and little community support to treat their medical and psychiatric issues; and

WHEREAS, the American Osteopathic Association has previously stated their support of efforts aimed at addressing the root causes of homelessness in House resolution H-428 – A/2018; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) reaffirm support for ~~all~~ state and federal efforts, including efforts by private organizations, as well as those enumerated in the 2018 House of Delegates resolution number H-428 – A/2018, and that those efforts include addressing social determinants ~~of~~ AFFECTING health, substance abuse programs, mental health resources, clinical care programs and provision of stable housing for all homeless individuals that are seeking temporary or permanent shelter~~; and, be it further~~

~~RESOLVED, that the AOA, with the guidance of the Department of Educational Affairs and any other relevant department(s), develop recommendations for curriculum and submit them to the Commission on Osteopathic College Accreditation (COCA), American Association of Colleges of Osteopathic Medicine (AACOM), National Board of Osteopathic Medical Examiners(NBOME), Accreditation Council for Graduate Medical Education (ACGME), and other educational entities at all levels of osteopathic medical education, including undergraduate, postgraduate, and osteopathic continuing medical education, in order to address healthcare issues related to clinical and social aspects of homelessness and report to the AOA House of Delegates at its July 2021 meeting~~.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: MEDICAL AMNESTY FOR UNDERAGE CONSUMPTION OF ALCOHOL

SUBMITTED BY: American Osteopathic Academy of Addiction Medicine

REFERRED TO: Committee on Public Affairs

WHEREAS, state laws prohibit the consumption of alcohol below the age of twenty-one (21) years; and

WHEREAS, people aged 12 to 20 years drink 11% of all alcohol consumed in the United States; and

WHEREAS, underage drinkers and associated social contacts are often reticent to seek medical help for themselves or their ill peers for fear of legal reprisal, resulting in tragic and unnecessary deaths; now, therefore be it

RESOLVED, that legal immunity for the underage consumption of alcohol for those who consume alcohol underage and seek medical attention, as well as any "Good Samaritans" who aid in their seeking of medical attention, should be the *de jure* standard in each state, enacted into law by state legislatures; and, be it further

RESOLVED, that this legal immunity applies specifically and exclusively to the consumption of alcohol before the legal age, but *not* for any infractions or crimes committed while under the influence of alcohol or as a result of the consumption of alcohol (e.g. driving under the influence, physical altercations, etc.); and, be it further

RESOLVED, that the American Osteopathic Association (AOA) supports full legal immunity for these individuals, and urge state and national lawmakers to enact "Good Samaritan" laws to increase access to life-saving medical care for underage consumers of alcohol.

Explanatory Statement: Submitted by Author
Instances of excessive drinking involving the death of minors could be avoided if minors can seek medical assistance without fear of criminal charges, including manslaughter.

Explanatory Statement: Reference Committee
Refer back to the American Osteopathic Academy of Addiction Medicine for clarification.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to American Osteopathic Academy of Addiction Medicine)*

DATE: **October 14, 2020**

SUBJECT: BREASTFEEDING WHILE ON MEDICATION ASSISTED TREATMENT (MAT) (Response to RES. NO. H-415 - A/2019, Referencing H-417-A/14 BREASTFEEDING WHILE ON METHADONE MAINTENANCE)

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, sunset resolution H-415 - A/2019, titled "BREASTFEEDING WHILE ON METHADONE MAINTENANCE", was referred to the Bureau on Scientific Affairs and Public Health (BSAPH) to evaluate breastfeeding and other forms of medication assisted treatment (MAT) for opioid addiction, not just methadone; now therefore be it,

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the attached white paper, titled, "BREASTFEEDING WHILE ON MEDICATION ASSISTED TREATMENT (MAT)", and the recommendations within be adopted as policy.

Breastfeeding While on Medication Assisted Therapy

Introduction

Opioid use among pregnant women is a growing public health concern. In 2014, the Centers for Disease Control and Prevention (CDC) recorded a 333% national increase in opioid use disorder (OUD) among pregnant women, with 6.5 cases of opioid abuse per 1,000 hospital deliveries, compared to 1.5 cases in 1999.[1] Opioid use during pregnancy is not uncommon; as many as 1 in 5 pregnant women enrolled in Medicaid filled an opioid prescription during their pregnancy.[2] Prenatal opioid exposure has been directly linked to adverse health outcomes for mothers and babies across the nation. These adverse health outcomes include increased maternal mortality and morbidity, poor fetal development, preterm births, still births, birth defects, and increased incidence of Neonatal Abstinence Syndrome (NAS).[3]

Studies have found that breastfeeding among women being treated for OUD offers many benefits that can mitigate the impacts of OUD for the mother and infant. Benefits include, but are not limited to, reduced hospital stays and decreased need for morphine treatment in infants born with NAS.[4]

Opioid Use Disorder Treatment

Medication Assisted Treatment, or MAT, is defined as the use of medications in combination with counseling and behavioral therapies to treat OUD and aid patients in sustaining their recovery.[5] MAT may be utilized with pregnant women to treat opioid use disorder and avoid the severe consequences associated with untreated opioid use disorder or stopping opioid usage too quickly. The U.S. Food and Drug Administration has approved three medications, buprenorphine, methadone, and naltrexone for OUD treatment.[5]

Naltrexone is the newest therapy approved by the U.S. Food and Drug Administration to treat opioid use disorder in pregnant women. Since it is also the least studied therapy, there is a research gap regarding the safety and effectiveness of naltrexone during pregnancy.[6] As a result, MAT for pregnant women commonly entails the use of methadone or buprenorphine with naloxone, in conjunction with coordinated care among behavioral therapists, OB-GYNs, and addiction specialists.[7] Both methadone and buprenorphine treatment

are endorsed by the American College of Obstetricians and Gynecologists and the American Society of Addiction Medicine as best practices for addressing opioid use during pregnancy.[4]

Methadone, a long-acting opioid agonist that decreases the desire to take opioids, was established as the standard of care in 1998 for treating OUD in pregnant women. The Substance Abuse and Mental Health Service Administration (SAMHSA) identified methadone as a safe drug to take while pregnant or preparing for pregnancy, along with counseling and participation in social support programs.[8]

Recently, The American Society of Addiction Medicine (ASAM) recognized Buprenorphine combined with Naloxone as the standard of care for the treatment of women who are pregnant or breastfeeding with OUD. The American Osteopathic Academy of Addiction Medicine (AOAAM) supports ASAM consensus that the combination of Buprenorphine and Naloxone is regularly used, safe, and effective.[9] Buprenorphine is the first medication to treat opioid use disorder that was authorized to be administered in physician offices, resulting in improved access to treatment.[10] Studies indicate that buprenorphine reduces fluctuations in fetal levels of opioids, minimizes repeated prenatal withdrawal, decreases overdoses, and limits drug interactions.[10]

Neonatal withdrawal, also called neonatal abstinence syndrome (NAS), is an anticipated and treatable condition caused by perinatal exposure to opioids, including methadone and the combination of buprenorphine with naloxone.[11] Although NAS may still occur in infants whose mothers receive MAT, the symptoms are milder than they would be without treatment.[4]

Postpartum, both infants and women on maintenance therapies can experience greater benefits through breast feeding. Although trace amounts of both methadone and buprenorphine have been found to seep into breast milk, research has shown that the benefits of breastfeeding outweigh the negligible risk associated with the medication that enters breast milk.[8, 10]

Breastfeeding

Because of the associated benefits, exclusive breastfeeding, without other supplementation, is recommended for healthy women by both the American Academy of Pediatrics and the World Health Organization for the first 6 months of life.[12,13] Breastfeeding contributes to attachment between a woman and her infant, encourages skin-to-skin contact.[11] The antibodies and hormones found in breast milk defend the infant's immune system against illness and lower the risk of asthma, leukemia, childhood obesity, lower respiratory infections, eczema, diarrhea, vomiting, and Sudden Infant Death Syndrome.[14] Breastfeeding also improves the health of mothers post-delivery, simultaneously, lowering potential risk for diabetes, breast cancer, and ovarian cancer. Breast milk is also easier for infants to digest and cost efficient for parents.[14]

The American Academy of Pediatrics (AAP) recommendation applies to women who take methadone or buprenorphine as well, without regard for dosage.[15] Breastfeeding among women who are opioid dependent is also encouraged by both, the American College of Obstetricians and Gynecologists (ACOG) and the American College of Osteopathic Obstetricians and Gynecologists (ACOOG), as long as the women are taking methadone or buprenorphine consistently, abstaining from illicit drugs, and have no underlying complexities or conditions, such as human immunodeficiency virus (HIV) and or Hepatitis C with open/bleeding and cracked nipples.[11] Additionally, The ACOOG supports the ACOG committee review that women in the post-partum period who return to using street drugs and are not on stable OUD therapy should restrain from breastfeeding.[16] After 6 months, the AAP recommends continuation of breastfeeding, alongside introduction of complementary foods during the first year of life.[12]

In spite of these endorsements, less than 25% of mothers exclusively breastfeed for 6 months in the United States.[12] Formula supplementation of breast milk is commonly utilized. Supplementation is reportedly associated with many side effects that can lead to adverse infant and maternal outcomes. Formula supplements can negatively impact the "maternal milk supply, the duration of exclusive breastfeeding, and

the infant's gut microbiome; alteration of the neonatal gut environment can be responsible for mucosal inflammation and disease, autoimmunity disorders, and allergic conditions in both childhood and adulthood".[17]

The Centers for Disease Control and Prevention established the breastfeeding report card, which provides national data on breastfeeding rates, breastfeeding support indicators, and breastfeeding practices.[12] The breastfeeding report card indicates that, in 2015, 83.2% of infants were breastfed starting at birth, 57.6% were still breastfed at some level at 6 months, and 35.9% at 12 months.[12] This data suggests that "the early postpartum period is a critical time for establishing breastfeeding, but mothers may not be getting the support they need from health care providers, family members, and employers to meet their breastfeeding goals".[12]

Uptake of breastfeeding is likely even lower among women with OUD. National Institute on Drug Abuse (NIDA) states that the rate of breastfeeding is normally "low" among mothers with OUD. Increased formal breastfeeding education, direct support for mothers, health care providers training on breastfeeding techniques, and peer support are all effective interventions that promote the start and sustainability of breastfeeding among mothers.[18]

Conclusion

Increasing rates of maternal opioid use during pregnancy and NAS are public health concerns. The utilization of MAT with methadone or buprenorphine has been approved as a safe mechanism for combatting opioid use during pregnancy and while breastfeeding.

Breastfeeding improves maternal and infant morbidity and mortality and decreases the impact of adverse health conditions. Breastfeeding infants who were exposed to opioids prenatally have the added advantage of lessening the impact of other conditions, such as NAS. Encouraging breastfeeding among mothers with exposure to opioids, who are undergoing MAT, is a significant step toward addressing OUD and NAS and improving maternal and child health. It shall be noted that the ACOOG and AOAAM supports the content of this paper and the policy recommendations outlined to encourage exclusive breastfeeding among mothers with a history of OUD.

American Osteopathic Association Policy

Given the research surrounding the positive impact of breastfeeding, the American Osteopathic Association adopts the following policy statements as its official position on breastfeeding among mothers with exposure to opioid use disorder in the United States:

1. The American Osteopathic Association (AOA) acknowledges that exclusive breastfeeding significantly improves maternal and infant health outcomes.
2. The American Osteopathic Association supports methadone and buprenorphine/naloxone assisted treatment as standards of care for addressing opioid use disorder during pregnancy and in the postpartum period.
3. The American Osteopathic Association (AOA) encourages exclusive breastfeeding among mothers with a history of Opioid Use Disorder (OUD), who are under physician care, actively engaged in a recovery program, on appropriate opioid agonists (methadone or buprenorphine), abstaining from illicit drugs, and who have no other contraindications, such as human immunodeficiency virus (HIV) infection and or Hepatitis C with open/bleeding and cracked nipples.
4. The American Osteopathic Association (AOA) recommends the use of counseling, coordination of care, and social support for mothers during pregnancy and breastfeeding in the postpartum period.

References:

[1] Haight SC, KO JY, Tong VT, Bohm MK, Callaghan WM. *Opioid Use Disorder Documented at Delivery Hospitalization – United States, 199-2014*. MMWR Morb Mortal Wkly Rep 2018; 67:845-849

[2] Desai RJ, Hernandez-Diaz S, Bateman BT, Huybrechts KF. *Increase in Prescription Opioid Use During Pregnancy Among Medicaid-Enrolled Women*. Obstetric Gynecology 2014; 123-997-1002.

[3] Jilani SM, Frey MT, Pepin D, et al. *Evaluation of State – Mandated Reporting of Neonatal Abstinence Syndrome – Six States, 2013 – 2017*. MMWR Morb Mortal Wkly Rep 2019; 68; 6-10

[4] National Institute on Drug Abuse. *Treating Opioid Use Disorder During Pregnancy*. (2017); Retrieved From https://www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy/treating-opioid-use-disorder-during-pregnancy#ref

[5] U.S. Food and Drug Administration. *Information about Medication Assisted Treatment – MAT*. (2020); Retrieved from https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat

[6] National Institute on Drug Abuse. *Could Naltrexone Be Used to Treat Pregnant Women with Opioid Addiction*. (2018); Retrieved From https://www.drugabuse.gov/about-nida/noras-blog/2018/02/could-naltrexone-be-used-to-treat-pregnant-women-opioid-addiction

[7] Centers for Disease Control and Prevention. *Basics About Opioid Use During Pregnancy*. 2019; Retrieved From https://www.cdc.gov/pregnancy/opioids/basics.html

[8] Substance Abuse and Mental Health Services Administration. *Methadone*. (2020); Retrieved From https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone

[9] The American Society of Addiction Medicine. *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder 2020 Focused Update*. 2020. Page 51 Received From https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2

[10] Substance Abuse and Mental Health Services Administration. *Buprenorphine*. (2019); Retrieved From https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine

[11] The American College of Obstetricians and Gynecologists. *Opioid Use and Opioid Use Disorder in Pregnancy*. (2017). Retrieved From https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

[12] Centers for Disease Control and Prevention. *Breastfeeding Report Card*. (2018). Retrieved From https://www.cdc.gov/breastfeeding/data/reportcard.htm

[13] The World Health Organization. *Exclusive Breastfeeding for Optimal Growth, Development, and Health of Infants*. (2020); Retrieved From https://www.who.int/elena/titles/exclusive_breastfeeding/en/

[14] U.S. Department of Health & Human Services. Office on Women's Health. *Making the Decision to Breastfeed*. (2020). Retrieved From https://www.womenshealth.gov/breastfeeding/making-decision-breastfeed

[15] The American College of Obstetricians and Gynecologists. *Opioid Use and Opioid Use Disorder in Pregnancy*. (2017). Retrieved From https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

[16] Committee on Obstetric Practice. Committee Opinion No. 711: *Opioid Use and Opioid Use Disorder in Pregnancy*. Obstetric Gynecol. 2017;130(2): e81-e94. doi:10.1097/AOG.0000000000002235

[17] Walker, Formula Supplementation of Breastfed Infants: Helpful or Hazardous? *ICAN: Infant, Child, & Adolescent Nutrition*, (2015) *7*(4), 198–207.https://doi.org/10.1177/1941406415591208

[18] Agency for Health Care Research and Quality. Rockville, MD. *Section 2.0 Recommendations for Adults.* (2014) Retrieved From https://www.ahrq.gov/prevention/guidelines/guide/section2.html

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy:
H428-A/17 BREASTFEEDING – PROMOTION, PROTECTION AND SUPPORT OF
H425-A/18 BREASTFEEDING EXCLUSIVITY

Prior HOD action on similar or same topic: H428-A/17 policy revised in 2017; H425-A/18 policy reaffirmed as amended 2018

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: REFERRED SUNSET RES. NO. H-411 - A/2019: H413-A/14 EPIDEMIC TERRORIST ATTACK VICTIMS, GOVERNMENT RESPONSIBILITY OF HEALTH CARE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

WHEREAS, the AOA House of Delegates referred sunset resolution H-411-A/2019 titled H413-A/14 EPIDEMIC TERRORIST ATTACK VICTIMS, GOVERNMENT RESPONSIBILITY OF HEALTH CARE to the Bureau on Federal Health Programs for "clarity on who should be included, who will benefit, definition of terrorist act, and if this is a national or international policy; now, therefore be it

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED:

H413-A/14 ~~EPIDEMIC~~ DOMESTIC OR FOREIGN TERRORIST ATTACK VICTIMS, GOVERNMENT RESPONSIBILITY OF HEALTH CARE

The American Osteopathic Association SUPPORTS **ALL HEALTHCARE PERSONNEL AND** FIRST RESPONDERS AND ~~believes that~~ victims of ~~an epidemic~~ DOMESTIC OR FOREIGN terrorist attackS ~~(e.g., anthrax) are victims of a new age conflict against America and as victims of an attack against America; they~~ IN THE UNITED STATES BEING~~should be~~ eligible for healthcare TREATMENT STEMMING FROM THE ACT to be covered by the United States Government. 2004; reaffirmed as amended 2009; reaffirmed 2014

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: H429 A/14 MINORITIES, UNDERREPRESENTED (URM) – INCREASING NUMBERS OF APPLICANTS, GRADUATES, AND FACULTY AT COLLEGES OF OSTEOPATHIC MEDICINE

SUBMITTED BY: Bureau of Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS sunset resolution. H-421 – A/2019 titled "MINORITIES, UNDERREPRESENTED (URM) – INCREASING NUMBERS OF APPLICANTS, GRADUATES, AND FACULTY AT COLLEGES OF OSTEOPATHIC MEDICINE", was referred to the Bureau of Scientific Affairs and Public Health for an analysis of the statistics to determine if the target deadline should be extended; now, therefore be it

RESOLVED, that the Bureau of Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED AS AMENDED:

H429 A/14 MINORITIES, UNDERREPRESENTED (URM) – INCREASING NUMBERS OF APPLICANTS, GRADUATES, AND FACULTY AT COLLEGES OF OSTEOPATHIC MEDICINE

The American Osteopathic Association encourages an increase in the total number of URM[1] graduates from colleges of osteopathic medicine by the year ~~**2020**~~ **2025** and encourages an increase in the total number of URM faculty by the year **2025** ~~2020~~. 2014

Explanatory Statement: Submitted by Author

INTRODUCTION

It is widely accepted that increasing racial and ethnic diversity among health professionals is associated with improved health outcomes for racial and ethnic minority patients, greater patient satisfaction, and better educational experiences for medical students.

Despite this widespread recognition, in 2017, the Health Resources and Services Administration (HRSA) Bureau of Health Workforce reported that "all minority groups, except Asians, are underrepresented in Health Diagnosis and Treating occupations."[2] Osteopathic physicians and faculty are included in these occupations.

PROGRESS

The American Osteopathic College of Osteopathic Medical Application Service (AOCOMAS) publication, titled, "AACOMAS Applicants to Osteopathic Medical Schools by Race and Ethnicity", tabulated the number and percentage of Underrepresented Minorities (URM). The report states that in academic year 2013-14, 11.7% and 2019-20, 17.0% identified as URM. Thus, there was an absolute increase of 5.3% in the applications submitted from URM over 6 years.[3]

While there was an improvement in the application rate of URM to osteopathic colleges, the same was not observed in the graduation rate. The American Association of Colleges of Osteopathic Medicine

(AACOM) publication, "Graduates of US Osteopathic Medical School by Race/Ethnicity", reported that for the academic year 2011-12, 8.4% of graduates identified as Hispanic/Latino; American Indian and Alaskan Native, non-Hispanic; Black/African American, non-Hispanic; Pacific Islander, non-Hispanic. In 2017-18, the most recent data, 8.2% of graduates identified as the same ethnic and racial groups. In other words, over a 6-year period, the proportion of medical school graduates, who identified as belonging to an URM group, had an absolute decline of 0.2%.[4]

Additionally, according to the most recent AACOM reports titled, "2012-13 Osteopathic Medical College Faculty by Race/Ethnicity"[5] and "2016-17 Osteopathic Medical College Faculty by Race/Ethnicity"[6], there were 1,164 of a total 37,197 (3.1%) faculty in academic year 2012-13, and 1,710 of a total 46,848.39 (3.6%) faculty in academic year 2016-17 who identified as Hispanic, American Indian/Alaskan Native, non-Hispanic; Black/African American, non-Hispanic; and Pacific Islander, non-Hispanic. Thus, the absolute change in faculty employed at an osteopathic college was 0.5% over the 4-year period.

CONCLUSION/RECOMMENDATIONS

There has been modest progress in increasing the proportion of applicants and faculty at osteopathic medical schools who identify as URM, current statistics are far from that of the general population. There has been little improvement in the graduation rate among URM. Given that the proportion of racial and ethnic minorities in the United States exceeded 18% at the most recent Census and is progressively climbing, it is recommended that the AOA and the AACOM continue to prioritize the development of an osteopathic workforce that more closely represents the people served by the profession.

REFERENCES

1. i.e., Hispanic/Latino ethnicity, Black or African American, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander
2. (2017). Sex, Race, and Ethnic Diversity of U.S. Health Occupations (2011-2015). U.S. Department of Health and Human Services Health Resources and Services Administration, Bureau of Health Workforce National Center for Health Workforce Analysis. Retrieved 3 27, 2020, from https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/diversityushealthoccupations.pdf
3. American Association of Colleges of Osteopathic Medicine. (2018). Applicants by Race and Ethnicity 1976-2019. Washington, DC: American Association of Colleges of Osteopathic Medicine. Retrieved 3 31, 2020, from https://www.aacom.org/reports-programs-initiatives/aacom-reports/applicants
4. American Association of Colleges of Osteopathic Medicine. (2015). Graduates by Race and Ethnicity 1985-2018. Washington, DC: American Association of Colleges of Osteopathic Medicine. Retrieved 3 31, 2020, from https://www.aacom.org/reports-programs-initiatives/aacom-reports/graduates-and-gme
5. American Association of Colleges of Osteopathic Medicine. (2014). 2012-13 Osteopathic Medical College Faculty by Race-Ethnicity. Washington, DC: American Association of Colleges of Osteopathic Medicine. Retrieved 3 31, 2020, from https://www.aacom.org/docs/default-source/archive-data-and-trends/2012-13-com-facbyre.pdf?sfvrsn=ee416197_14
6. American Association of Colleges of Osteopathic Medicine. (2018). 2016-17 Osteopathic Medical College Faculty by Race/Ethnicity. Washington, DC: American Association of Colleges of Osteopathic Medicine. Retrieved 3 27, 2020, from https://www.aacom.org/docs/default-source/data-and-trends/2016-17-osteopathic-medical-college-faculty-by-race-ethnicity.pdf?sfvrsn=1b12597_6

Background Information: Provided by AOA Staff
Current AOA Policy:
H433-A/15 MINORITY HEALTH DISPARITIES
H323-A/19 MINORITIES IN THE OSTEOPATHIC PROFESSION – COLLECTING DATA

Prior HOD action on similar or same topic: 433-A/15 policy reaffirmed in 2015; H323-A/19 policy reaffirmed as amended in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: REGULATION OF E-CIGARETTES AND NICOTINE VAPING
(Response to RES. NO. H - 424 - A/2019 referencing H - 435 - A/2014)

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, RES. NO. H-424 - A/2019 was referred to the Bureaus of Scientific Affairs and Public Health to update the white paper; now, therefore be it

RESOLVED, that the following policy paper and the recommendations provided within be adopted as the amended policy of the AOA.

REGULATION OF E-CIGARETTES AND NICOTINE VAPING

BACKGROUND

The adverse health effects associated with tobacco use are well documented public health concerns. Smoking can damage every human organ, and it can lead to death from heart disease, cancers or strokes. According to the World Health Organization (WHO), 1 in 10 deaths each year, or nearly 8 million deaths around the world, are caused by tobacco use.[1,2] More than 7 million of those deaths are the result of direct tobacco use, while around 1.2 million are the result of non-smokers being exposed to second-hand smoke.[2] In the United States, this translates to 480,000 deaths per year from cigarette smoking and second-hand smoke exposure.[3]

In response to the negative health effects of tobacco products and cigarettes in particular, a natural market for smoking cessation and reduction products has emerged over the past 4 decades.[4] The use of electronic nicotine delivery systems (ENDS), such as electronic cigarettes (e-cigarettes), has reached a rapidly expanding consumer base.[5] E-cigarettes are often used or promoted to reduce consumption of tobacco products.[6] Alternative strategies for reaching smoking cessation goals include switching to low or light cigarettes or using nicotine-infused chewing gum, lozenges, lollipops, dermal patches or hypnosis.[7]

In the US, e-cigarettes are the most frequently utilized tobacco product among youth, who are also more likely than adults to use them. In 2019, over 5 million US middle and high school students had used e-cigarettes in the past 30 days.[8] In 2018, 3.2% of US adults were current e-cigarette users.[9]

The name e-cigarette is an umbrella term that includes any battery-powered device that vaporizes liquid nicotine for delivery via inhalation. These devices are most commonly referred to as electronic cigarettes, e-cigarettes, e-cigs, vaping, vape pens, vape pipes, hookah pens, e-hookahs, but could potentially be referred to by other terms. Since its 2007 introduction in the United States, the e-cigarette market has grown to include more than 460 brands.[10] E-cigarettes are a 2.5 billion dollar business in the United States.[11] The attraction to e-cigarettes crosses many segments of the population, appealing to tobacco cigarette smokers trying to quit as well as non-smokers who want to try nicotine without the harmful additives.[12] Though some states and municipalities have started to ban e-cigarettes, tobacco cigarette smokers can use e-cigarettes as a source of nicotine in some venues where conventional cigarettes are banned.

Costs associated with smoking-related illnesses continue to escalate. In 2014, smoking-related illness costs in the United States were more than $300 billion each year, including approximately $170 billion for direct medical care for adults, and more than $156 billion in lost productivity. Nearly $5.6 billion of the lost productivity cost was due to secondhand smoke exposure.[13]

Overall, e-cigarettes may be less harmful for heavy or moderate smokers because they may reduce exposure to carcinogens and other toxic chemicals that cause serious disease and death.[14] However, the effect of long term consumption of nicotine and associated aerosols remains unclear. Studies have shown that e-cigarette vapors may be harmful, particularly in places with limited ventilation and for people with compromised health. Furthermore, e-juice liquids have been found to increase accidental poisonings in children. The full scale of health and safety hazards of vaping for users and secondhand users is undetermined.[15]

ANALYSIS

Regulation of e-cigarettes by the Food and Drug Administration (FDA) only began in earnest in 2016. The Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act) provided the FDA authority to regulate the manufacture, marketing and distribution of tobacco products.[16] However, e-cigarettes were not initially included in the FDA's regulation of tobacco products. Unlike tobacco cigarettes, e-cigarettes have enjoyed the ability to advertise on television and radio.[17] This allows e-cigarette companies to market their product in a more liberal fashion in response to market demands, including the use of celebrity endorsements.[18] However, some manufacturers have voluntarily begun to limit their advertising in an attempt to avoid federally imposed restrictions on advertising.

The Composition of E-Cigarettes

The e-cigarette is a smokeless, battery-powered device that vaporizes liquid nicotine for delivery via inhalation.[19] Using an e-cigarette may also be referred to as "vaping", or as "juuling", the branded form of flavored e-cigarettes popular among younger consumers. The e-cigarette contains nicotine derived from tobacco plant and several secondary chemical ingredients.[20] It is primarily composed of a nicotine cartridge, atomizer, and a battery.[21] The atomizer, which converts the nicotine liquid into a fine mist, consists of a metal wick and heating element.[22] When screwed onto the cartridge, the nicotine liquid from the cartridge, which could also include flavoring, comes into contact with the atomizer unit and is carried to the metal coil heating element.[23] A single cartridge can hold the nicotine equivalent of an entire pack of traditional cigarettes.[24] E-cigarettes can also be used to deliver marijuana and other drugs.[25]

While the typical e-cigarette is sold in the shape of a cigarette, many products are sold in the shape of discreet objects such as pipes, pens, lipsticks, and other everyday items.[26] Often, they can be legally used where traditional tobacco products are banned.

Federal Efforts to Regulate

In 2016, the FDA finalized a rule extending regulatory authority to cover all tobacco products, including electronic nicotine delivery systems (ENDS) that meet the definition of a tobacco product.[27] The FDA now regulates the manufacture, import, packaging, labeling, advertising, promotion, sale, and distribution of ENDS. Prior to this rule, the FDA could regulate e-cigarettes only if the manufacturer made a therapeutic claim, such as the product was being marketed as a cessation device.[28]

The rule established restrictions on youth access to newly regulated tobacco products by: (1) banning their sale to individuals younger than 18 years of age (federal legislation raised this to 21 years in 2019)

and requiring age verification via photo ID; and (2) prohibiting the sale of tobacco products in vending machines (unless in an adult-only facility).[29]

The Federal Food, Drug, and Cosmetic Act was signed into law on December 20, 2019, and raised the federal minimum age of sale for tobacco products from 18 to 21 years.[30] Retailers are now prohibited from selling tobacco products to anyone under the age of 21.

Further, in January 2020, the FDA banned all mint- and fruit-flavored e-cigarettes, but exempted menthol- and tobacco-flavored products, in an effort to target products widely used by minors while preserving an "off-ramp" for adults who are trying to quit smoking.[31]

Tobacco is a major threat to public health, and one of the goals of the FDA is to protect Americans from tobacco-related diseases and death. This rule allows the FDA to protect youth by restricting their access to tobacco products, helps consumers better understand the risks of using these products, prohibits false and misleading product claims, and prevents new tobacco products from being marketed unless a manufacturer demonstrates that the product meets relevant public health standards.

State Efforts to Regulate

Various states and municipalities have also enacted laws restricting the sale of e-cigarettes.[32] Twenty-seven states, along with the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, and 1,107 municipalities have passed laws that ban smoking in all non-hospitality workplaces, restaurants, and bars; of these, 22 states and 929 municipalities also restrict e-cigarette use in 100% smoke-free venues.[33]

In November 2019, **Massachusetts** became the first state to restrict the sale of *all* flavored tobacco products, including e-cigarettes and menthol cigarettes.[34] **New Jersey** prohibited the use of e-cigarettes in all enclosed indoor places of public access as well as in working places, and in January 2020, the state enacted legislation banning the sale of *all* flavored e-cigarettes.[35,36] In March 2020, **Rhode Island** also announced a permanent ban on the sale of flavored e-cigarettes.[37] Six other states (Michigan, Montana, New York, Oregon, Utah and Washington) temporarily banned the sale of flavored e-cigarettes in 2019, but of those, only Montana's and Washington's bans are currently in effect while the others are facing various legal challenges.[38]

As of 2019, twenty-three (23) states and the District of Columbia have enacted statutes which require licenses for retail sales of e-cigarettes.[39]

Arguments for E-Cigarettes

Proponents of e-cigarettes consider e-cigarettes to be less harmful than traditional tobacco products and believe they increase adult smoking cessation.[40] While it has been established that e-cigarettes contain fewer carcinogenic elements than traditional tobacco cigarettes, the long-term health effects of e-cigarette use are unknown.[41] According to the American Lung Association there are approximately 600 ingredients in cigarettes.[42] When burned, they create more than 7,000 chemicals.[43] At least 69 of these chemicals are known to cause cancer, and many are poisonous.[44] While e-cigarettes may have fewer component chemicals, a study found that the usage of e-cigarettes contributes to indoor air contamination.[45] A 2016 report from the WHO determined that second-hand aerosols from e-cigarettes are a new source of pollution for hazardous particulate matter (PM). The levels of nickel, chromium, and other metals found in second-hand aerosols are higher than ambient air and higher than second-hand tobacco smoke.[46]

The greatest appeal of e-cigarettes for smoking cessation is that they deliver nicotine to alleviate nicotine withdrawal symptoms. E-cigarettes evoke the psychological response to cigarette smoking because of its shape and the familiar behavior aspect of smoking.[47] A 2011 survey of 104 e-cigarette users revealed that 66% started using them with the intention to quit smoking and almost all felt that the e-cigarette had helped them to succeed in quitting smoking.[48] Another survey of 3,037 e-cigarette users revealed that 77% of respondents used e-cigarettes to quit smoking or to avoid relapse.[49] None said they used them to reduce consumption of tobacco with no intent to quit smoking.[50] However, the overall effectiveness of e-cigarettes is still in question. In a randomized study, participants given e-cigarettes, nicotine patches and placebo e-cigarettes that lacked nicotine were able to quit smoking at roughly the same rates, with insufficient statistical power to conclude superiority of nicotine e-cigarettes.[51]

Consequences of E-Cigarettes

Advocates of e-cigarettes contend that e-cigarettes are less risky than traditional tobacco products and can serve as a mode of harm reduction by reducing smoking or serving as a smoking cessation strategy.[52] While there is limited evidence that suggests that adult smokers could benefit from e-cigarette use instead of combustible tobacco products, smokers would need to fully switch to e-cigarettes and stop smoking cigarettes and other tobacco products completely to achieve any meaningful health benefits from e-cigarettes. Experts who serve on the US Preventive Services Task Force have resolved that there is insufficient evidence to recommend e-cigarettes for smoking cessation in adults, including pregnant women. Thus, e-cigarettes are not currently approved by the FDA as an aid to quit smoking.[53]

Another major concern is that e-cigarettes appeal to youth by being flavorful, trendy and a convenient accessory.[54] The flavorings being used, such as candy and other sweet flavorings are particularly attractive to younger populations. For this reason, these flavorings are banned in traditional cigarettes.[55] Despite a downturn prior to 2017, e-cigarette use among youth has drastically increased. From 2017 to 2018, the percent of middle school students who used e-cigarettes increased 48%, resulting in 570,000 middle school students, or 4.9%, who were current e-cigarette users. Among high school students during the same period, current e-cigarette use, defined as use at least one day in the past 30 days, increased by 78%, from 11.7% to 20.8%, the equivalent of 3.05 million high school students using e-cigarettes in 2018. Current e-cigarette users in high school who reported use on 20 days or more in the past 30-day period increased from 20% to 27.7%. During the same timeframe, use of flavored e-cigarettes increased among high school students who currently used e-cigarettes as well. Use of any flavored e-cigarette went up among current users from 60.9% to 67.8%, and menthol use increased from 42.3% to 51.2% among all current e-cigarette users, including consumers of multiple products, and from 21.4% to 38.1% among those using only e-cigarettes. From 2018 to 2019, the number of middle school and high school students who reportedly used e-cigarettes in the past 30 days increased from a total of 3.6 million to 5.4 million youth.[56]

In addition to exposure to the carcinogenic and toxic effects of tobacco, smokers become addicted to the nicotine.[57] Nicotine addiction is characterized as a form of drug dependence recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V).[58] E-cigarette cartridges can contain up to 20 times the nicotine of a single cigarette, and the process of vaping lacks the normal cues associated with cigarette completion, such as the butt of the cigarette ending a dose.[59]

Conditioning has a secondary role in nicotine addiction. Smokers associate particular cues with the high of smoking, often causing relapse when those seeking to quit smoking are confronted with those cues.[60] E-cigarettes allow quitting smokers to respond to those cues. This poses a risk of overconsumption. The lack of finality to an e-cigarette is determined only by the battery or nicotine cartridge.

Distinguishable from tobacco cigarettes, smokers who have turned to the e-cigarette no longer have the butt of the cigarette as a cue to stop smoking.[61]

E-cigarettes can cause other inadvertent injuries as well. The CDC, the US Food and Drug Administration (FDA), state and local health departments, and other clinical and public health organizations have investigated a national outbreak of e-cigarette, or vaping, product use-associated lung injury (EVALI).[62] EVALI is an inflammatory response in the lungs triggered by inhaled substances. EVALI has been found to vary due to the substantial variety of products and ingredients used. It may present as pneumonia or an inflammatory condition known as fibrinous pneumonitis.[63] As of February 2020, 2,807 hospitalized EVALI cases or deaths were reported to CDC from all 50 states, the District of Columbia, Puerto Rico and U.S. Virgin Islands. Sixty-eight (68) deaths were confirmed in 29 states and the District of Columbia. Vitamin E acetate, an additive in some THC-containing e-cigarette products, was found to be strongly associated with the EVALI outbreak.[64]

Additionally, e-cigarettes are manufactured from metal and ion components that introduce concerns about faulty products and malfunctions.[65] Defective e-cigarette batteries have caused fires and explosions, some of which have resulted in serious injuries. Lithium-ion batteries have reportedly overheated, caught fire or exploded, an event known as thermal runaway. From 2015 to 2017, an estimated 2,035 e-cigarette explosions and burn injuries presented to hospital emergency departments. Although the explosions are relatively rare, they can cause severe injuries.[66]

CONCLUSION

The AOA supports FDA and state regulation of the ingredients in all electronic cigarette cartridges, requiring ingredient labels and warnings, and eliminating the use of flavors that are banned in traditional cigarettes.

The AOA supports FDA and state regulation prohibiting sales and advertisements of electronic cigarettes to persons under the age of 21. Advertisements for electronic cigarettes should be subject to the same rules and regulations that are enforced on traditional cigarettes.

The AOA further encourages federal, state and local government action to ban the use of electronic cigarette devices in all spaces where traditional cigarettes are currently barred from use.

The AOA promotes tobacco and nicotine cessation treatment, and the use of any such treatment that has been proven safe and effective by the FDA.

The AOA supports research by the FDA and other organizations into the health and safety impact of e-cigarettes and liquid nicotine.

The AOA encourages physicians to ~~**consider the health risks when recommending e-cigarettes to patients, to**~~ educate patients about the risks of e-cigarette use, and to counsel patients to submit voluntary reports to the US Department of Health and Human Services Safety Reporting Portal (www.safetyreporting.hhs.gov) if they sustain adverse reactions to e-cigarettes.

REFERENCES

1. WHO report on the global tobacco epidemic, 2017: monitoring tobacco use and prevention policies. Geneva: World Health Organization; 2017. License: CC BY-NC-SA 3.0 IGO.
2. Tobacco free initiative: tobacco facts, WHO available at https://www.who.int/news-room/fact-sheets/detail/tobacco
3. *Available* at https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm#diseases

4. Jordan Paradise, No Sisyphean Task: How the FDA Can Regulate Electronic Cigarettes, 13 Yale J. Health Pol'y L. & Ethics 326, 329 (2013).
5. Id. at 330.
6. Jordan Paradise at 329.
7. Id.
8. *Available* at https://www.cdc.gov/tobacco/basic_information/e-cigarettes/about-e-cigarettes.html#who-is-using-e-cigarettes
9. *Available* at https://www.cdc.gov/tobacco/data_statistics/sgr/2020-smoking-cessation/fact-sheets/adult-smoking-cessation-e-cigarettes-use/index.html
10. NIDA. (2020, January 8). Vaping Devices (Electronic Cigarettes). Retrieved from https://www.drugabuse.gov/publications/drugfacts/vaping-devices-electronic-cigarettes on 2020, May 21
11. Dan Radel, Healthy or Harmful? Smoking out the truth about e-cigarettes, *available* at http://special.app.com/article/20131027/NJLIFE04/310270144/Healthy-or-harmful-Smoking-out-the-truth-about-e-cigarettes
12. Id. at 331.
13. Available at https://www.cdc.gov/tobacco/data_statistics/fact_sheets/economics/econ_facts/index.htm#economic-costs; Accessed May 22, 2020.
14. Jordan Paradise at 333.
15. Marcham CL, Springston JP. Electronic cigarettes in the indoor environment. Rev Environ Health. 2019;34(2):105-124. doi:10.1515/reveh-2019-0012, *available at https://pubmed.ncbi.nlm.nih.gov/31112510/*
16. *Available* at http://publichealthlawcenter.org/sites/default/files/resources/tclc-fs-ftc&tobacco-2012.pdf
17. 15 U.S.C. § 1335.
18. Stuart Elliots, E-Cigarette Makers' Ads Echo Tobacco's Heyday, New York Times, August 29, 2013, *available at* http://www.nytimes.com/2013/08/30/business/media/e-cigarette-makers-ads-echo-tobaccos-heyday.html
19. Jordan Paradise at 353.
20. Id. at 353.
21. Tobacco fact sheet: Electronic Cigarettes (E-Cigarettes), Legacy for Longer Healthier Lives, *available* at http://www.legacyforhealth.org.
22. Jordan Paradise at 354.
23. Id.
24. *Available* at http://www.smokingeverywhere.com/cartridge.php.
25. *Available at* https://www.cdc.gov/tobacco/basic_information/e-cigarettes/about-e-cigarettes.html#what-are-e-cigarettes
26. Jordan Paradise at 354.
27. U.S. Food and Drug Administration, *Vaporizers, E-Cigarettes, and other Electronic Nicotine Delivery Systems (ENDS)*, Last updated: Sep. 12, 2019, https://www.fda.gov/tobacco-products/products-ingredients-components/vaporizers-e-cigarettes-and-other-electronic-nicotine-delivery-systems-ends
28. Sophie Novack, E-Cigarette Ads spark Lawmakers' Concern for Youth, The National Journal (Sept. 29, 2013).
29. U.S. Food and Drug Administration, Tobacco 21. https://www.fda.gov/tobacco-products/retail-sales-tobacco-products/tobacco-21
30. P.L. 116-94.
31. Alltucker, Ken. FDA Bans Mint- and Fruit-Flavored Vaping Products but Exempts Menthol and Tobacco. USA Today (Jan. 2, 2020). https://www.usatoday.com/story/news/health/2020/01/02/vaping-ban-fda-strikes-mint-and-fruit-flavored-products/2796299001/.
32. Jordan Paradise at 374.
33. American Nonsmokers' Rights Foundation., Overview List – Number of Smokefree and Other Tobacco-Related Laws. https://no-smoke.org/wp-content/uploads/pdf/mediaordlist.pdf.
34. Bach, Laura. States & Localities that Have Restricted the Sale of Flavored Tobacco Products. Campaign for Tobacco-Free Kids (Mar. 18, 2020). https://www.tobaccofreekids.org/assets/factsheets/0398.pdf.
35. N.J. Stat. Ann. SEC 26:3D-58.
36. Bach, Laura *supra.*
37. Id.
38. Id.
39. Public Health Law Center, *Retail Licensure on E-Cigarettes,* June 15, 2019, https://www.publichealthlawcenter.org/sites/default/files/States-with-Laws-Requiring-Licenses-for-Retail-Sales-of-ECigarettes-June152019.pdf

40. Daniel J. Denoon, E-cigarettes under fire, No-Smoke Electronic Cigarettes draw Criticism from FDA, quoting Craig Youngblood, president of InLife, e-cigarette company *available at* www.webmd.com/smoking-cessation/features/ecigarettes-under-fire.
41. Dan Radel, *supra* quoting Robert Lahita, Chair of Medicine at New Beth Israel Medical Center.
42. *Available* at https://www.lung.org/quit-smoking/smoking-facts/whats-in-a-cigarette; updated March 13, 2020.
43. Id.
44. Id.
45. Schober et al, Use of Electronic Cigarettes (E-Cigarettes) Impairs Indoor Air Quality and Increases FeNO Levels of E-Cigarette Consumers, International Journal of Hygiene Environment and Health.
46. Nick Wilson et. al., Should E-Cigarette Use be Included in Indoor Smoking Bans?, Bulletin of the World Health Organization, 95:540-541 (2017). *Available* at http://www9.who.int/bulletin/volumes/95/7/16-186536/en/
47. Michael B. Siegal et. al., Electronic Cigarettes as a Smoking-Cessation Tool: Results from an online Study, 40 Am. J. Preventive Med. 472, 474 (2011).
48. Jonathan Foulds et. al., Electronic Cigarettes (E-Cigs): Views of aficionados and Clinical/public health perspectives, 65 Int'l J. Clinical prac. 1037 (2011)
49. Id.
50. Id.
51. Christopher Bullen, Electronic Cigarettes For Smoking Cessation: A Randomised Controlled Trial, The Lancet, November 16, 2013, *available at* http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2961842-5/abstract
52. Jordan Paradise at 329.
53. *Available* at https://www.cdc.gov/tobacco/data_statistics/sgr/2020-smoking-cessation/fact-sheets/adult-smoking-cessation-e-cigarettes-use/index.html
54. Jordan Paradise at 329.
55. Bridget M. Kuehn, *supra.*
56. *Available* at https://www.cdc.gov/tobacco/basic_information/e-cigarettes/about-e-cigarettes.html#what-are-e-cigarettes
57. Neal L. Benowitz, Nicotine Addiction, 362 New. Eng. J. Med. 2295 (2010).
58. American Psychological Association, Diagnostic and Statistical Manual of Mental Disorders: DSM-V, 5th ed.; 2013. 571-4.
59. Jordan Paradise at 335.
60. Neal L. Benowitz, *supra.*
61. Jordan Paradise at 359.
62. *Available* at https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html#overview
63. EVALI: New information on vaping-induced lung injury; *Available* at https://www.health.harvard.edu/blog/evali-new-information-on-vaping-induced-lung-injury-2020040319359
64. *Available* at https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html#overview
65. Id. at 335.
66. Rossheim ME, Livingston MD, Soule EK, et alElectronic cigarette explosion and burn injuries, US Emergency Departments 2015–2017Tobacco Control 2019;28:472-474.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 14, 2020**

SUBJECT: RECOGNIZING HEALTH CARE AS A HUMAN RIGHT

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, there are many components that contribute to good health, including the ability to respond to sickness, disease and injury; and

WHEREAS, achieving the goal of living a healthy life is impossible without the ability to access health care; and

WHEREAS, health care should be available to everyone; and

WHEREAS, the lack of available health care is a barrier to opportunity, success and quality of life; and

WHEREAS, Osteopathic physicians and their patients' should not be divided between those who can afford to be healthy and those who cannot; and

WHEREAS, Osteopathic physicians and their patients' should not be divided between those who have hopes and dreams and those whose sickness, disease or injury robs them of their hopes and dreams; and,

WHEREAS, the World Health Organization recognizes "the highest attainable standard of health as a fundamental right of every human being," and "the right to health includes access to timely, acceptable, and affordable health care of appropriate quality [i]," and

WHEREAS, the United States ranks 33th out of 34 countries in the Organization for Economic Co-operation and Development (OECD) in percentage of insured population (with 88.5%), with nearly every other country at > 98% [ii], and

WHEREAS, 25-30 million Americans are still uninsured after implementation of the Affordable Care Act (ACA), and the non-partisan Congressional Budget Office estimates that this number would increase to 48 million, and continue to increase annually, with an ACA repeal [iii]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) recognizes that health care is a human right for every person [1], not a privilege as an official policy statement to inform and guide ongoing work of the AOA as a tenet of our osteopathic profession.

References:

[i] World Health Organization Media Center. "Health and Human Rights." Fact Sheet N 232, Dec 2015. Accessed Feb 2017. http://www.who.int/mediacentre/factsheets/fs323/en/

[ii] OECD (2015), Health at a Glance 2015: OECD Indicators, OECD Publishing, Paris. http://dx.doi.org/10.1787/health_glance-2015-en

[iii] Congressional Budget Office. "How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums." Jan 2017. https://www.cbo.gov/publication/52371

[iv] Bauchner, H. "Health Care in the United States: A Right or a Privilege." JAMA. 2017; 317(1):29. http://jamanetwork.com/journals/jama/fullarticle/2595503

[1] Journal of the American Medical Association (JAMA), the editor-in-chief of JAMA voiced a hope that all physicians and professional societies will "speak with a single voice and say that health care is a basic right for every person, and not a privilege to be available and affordable only for a majority[iv]."

Explanatory Statement: Submitted by Author

Resolution H431 – A/2019 was referred back to the Michigan Osteopathic Association, with a request "for clarity and direction". It has been revised and re-submitted for consideration by the AOA HOD.

Explanatory Statement: Reference Committee

The resolution was referred back to Michigan at the 2019 HOD meeting for "clarity and direction." However, the Committee believes that the resolution does not adequately define "healthcare as a human right" versus "health as a human right" and does not address the legal implications of defining healthcare as a human right.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **November 7, 2020**

RES. NO. H-431 - A/2019 – Page 1

SUBJECT: RECOGNITION OF HEALTH CARE AS A HUMAN RIGHT

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, the World Health Organization recognizes "the highest attainable standard of health as a fundamental right of every human being," and states "the right to health includes access to timely, acceptable, and affordable health care of appropriate quality"[1]; and

WHEREAS, the United States ranks 33rd out of 34 countries in the Organization for Economic Co-operation and Development (OECD) in percentage of insured population (with 88.5%), with nearly every other country at > 98%[2]; and

WHEREAS, 25-30 million Americans are still uninsured after implementation of the Affordable Care Act (ACA), and the non-partisan Congressional Budget Office estimates that this number would increase to 48 million, and continue to increase annually, with an ACA repeal[3]; now, therefore, be it

RESOLVED, that the American Osteopathic Association recognizes that health care is a human right for every person[4], not a privilege.

References:

1. World Health Organization Media Center. "Health and Human Rights." Fact Sheet N°232, Dec 2015. Accessed Feb 2017. http://www.who.int/mediacentre/factsheets/fs323/en/
2. OECD (2015), Health at a Glance 2015: OECD Indicators, OECD Publishing, Paris. http://dx.doi.org/10.1787/health_glance-2015-en
3. Congressional Budget Office. "How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums." Jan 2017. https://www.cbo.gov/publication/52371
4. Bauchner, H. "Health Care in the United States: A Right or a Privilege." JAMA. 2017; 317(1):29. http://jamanetwork.com/journals/jama/fullarticle/2595503 - Journal of the American Medical Association (JAMA), the editor-in-chief of JAMA voiced a hope that all physicians and professional societies will "speak with a single voice and say that health care is a basic right for every person, and not a privilege to be available and affordable only for a majority."

Reference Committee Explanatory Statement:
The committee believes that the resolution, as written, lacks clarity and direction.

ACTION TAKEN **REFERRED** *(to the Michigan Osteopathic Medical Association)*

DATE **July 27, 2019**

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
888.626.9262
osteopathic.org

SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
CONSTITUION & BYLAWS - RESOLUTION ROSTER
WITH ACTION

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:

- Committee on Constitution and Bylaws (500 series)
  This reference committee reviews and considers the wording of all proposed amendments to the AOA's Constitution, Bylaws and the Code of Ethics.

Res. No.	Resolution Title	Submitted By	Action
H500	Amendment to the American Osteopathic Association Bylaws – Implement Changes to Governance Structure	BOT	ADOPTED
H501	Amendments to the American Osteopathic Association Bylaws – Update to Bureau of Membership	BOT	ADOPTED
H502	Amendments to the American Osteopathic Association Bylaws – Procedure for Notice of Proposed Changes to Bylaws	BOT	ADOPTED

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – IMPLEMENT CHANGES TO GOVERNANCE STRUCTURE

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, the AOA Board of Trustees, on recommendation of the Committee on AOA Governance & Organizational Structure, has approved a resolution that calls for changes to the names by which some of the AOA's Departments are known to better identify their function within the AOA's governance structure; and

WHEREAS, it is necessary to amend the AOA's Constitution and Bylaws to reflect these changes to the Department names; now, therefore, be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws:

Old material crossed out (~~crossed out~~) | New material in CAPS

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 Affiliate~~d~~ 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.

Explanatory Statement: Submitted by Author

The AOA Board of Trustees approved changes to the organizational structure at its midyear meeting in February 2020, including renaming the six Departments as follows:

1. Affiliate Affairs to become Affiliate Relations
2. Business Affairs to become Finance
3. Educational Affairs to become Education
4. Governmental Affairs – no change
5. Professional Affairs to become Membership
6. Research Quality & Public Health to become Research and Public Health

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – UPDATE TO BUREAU OF MEMBERSHIP

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, the AOA's Committee on AOA Governance & Organizational Structure has reviewed the AOA's Constitution and Bylaws; and

WHEREAS, the AOA's Bylaws refer to the "Committee on Membership" which is now called the "Bureau of Membership"; now, therefore, be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws:

Old material crossed out (~~crossed out~~) | New material in CAPS

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.

Explanatory Statement: Submitted by Author

This amendment, if approved, will change references in the AOA's Bylaws from "Committee on Membership" to "Bureau of Membership."

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – PROCEDURE FOR NOTICE OF PROPOSED CHANGES TO BYLAWS

SUBMITTED BY: Committee on AOA Governance & Organizational Structure

REFERRED TO: Committee on Constitution & Bylaws

WHEREAS, the current procedure for amending the AOA's Bylaws calls for providing notice to members through publication in the JAOA and notice to affiliated organizations represented in the House of Delegates by U.S. mail; and

WHEREAS, the JAOA is transitioning to on-line publication and notice by electronic mail is more efficient and cost-effective than notice by U.S. mail; now, therefore, be it

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Bylaws:

Old material crossed out (~~crossed out~~) | New material in CAPS

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: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 14, 2020**

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
888.626.9262
osteopathic.org

SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
AD HOC - RESOLUTION ROSTER
WITHACTION

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:

- Ad Hoc Committee (600 series)
  This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.

Res. No.	Resolution Title	Submitted By	Action
H600	Dissemination of Publications in Osteopathic Research (H600-A/15)	BOCER	ADOPTED
H601	Reduction of Osteopathic Training Positions in Post-Graduate Medical Education (H601-A/15)	BOE	ADOPTED *(for sunset)*
H602	Reimbursement for Physician Time Spent Obtaining Pre-Certification and Pre-Authorization (H602-A/15)	BSA	ADOPTED *(for sunset)*
H603	Pay for Performance (H604-A/15)	BSA	ADOPTED as AMENDED
H604	Proper Badge Identification of Employees in a Hospital Setting (H606-A/15)	BSAPH	ADOPTED
H605	Interoperability of Health Information Technology (H607-A/15)	BSA	ADOPTED
H606	Gifts to Physicians from Industry (H612-A/15)	Ethics	ADOPTED
H607	Physician Competency Retesting (H614-A/15)	BOS	ADOPTED as AMENDED
H608	Health Plan Coverage of Tobacco Cessation Treatment (H615-A/15)	BSA	ADOPTED
H609	Encouraging Patient Participation in Their Health Care (H616-A/15)	BSAPH	ADOPTED
H610	Frivolous Liability Lawsuits (H617-A/15)	BFHP	ADOPTED *(for sunset)*
H611	Provider Tax (H618-A/15)	BSGA	ADOPTED
H612	Medicaid Payment (H619-A/15)	BSGA	ADOPTED as AMENDED
H613	Lay Midwives (H620-A/15)	BSGA	ADOPTED
H614	Medical Malpractice Judgments Requiring Reimbursement of Medicare Payments (H621-A/15)	BSA	REFERRED
H615	Electronic Health Records – Physician Assistance Programs for Transition to (H622-A/15)	BSA	ADOPTED as AMENDED
H616	Prescription Medications -- Overrides for (H624-A/15)	BSGA	NOT ADOPTED

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
888.626.9262
osteopathic.org

SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
AD HOC - RESOLUTION ROSTER
WITHACTION

Res. No.	Resolution Title	Submitted By	Action
H617	Pediatric Psychiatric Care Health Records (H625-A/15)	BSA / BSAPH	ADOPTED
H618	Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder (H626-A/15)	BSA	ADOPTED
H619	Medicare Recovery Audit Contractors (H628-A/15)	BSA	REFERRED
H620	Medicare Law and Rules (H629-A/15)	BFHP	REFERRED
H621	Veterans Administration Credentialing of Non-Physician Providers Health Records (H630-A/15)	BFHP	ADOPTED
H622	Tax Credits for Health Profession Shortage Areas (H631-A/15)	BFHP	ADOPTED
H623	Osteopathic Manipulative Treatment (OMT) in a Pre-Paid Environment –Payment Policies for (H632-A/15)	BSA	ADOPTED
H624	Prescription of Drugs for Off Label Uses (H633-A/15)	BFHP	ADOPTED
H625	Newborn and Infant Hearing Screens (H635-A/15)	BSAPH	ADOPTED
H626	Medicare Preventive Medical Screening (H636-A/15)	BFHP	ADOPTED
H627	Confidentiality of Patient Records (H637-A/15)	Ethics	ADOPTED
H628	Diabetics Confined to Correctional Institutions (H638-A/15)	BSAPH	ADOPTED
H629	Discrimination by Insurers (H639-A/15)	BSA	ADOPTED
H630	Executions in Capital Crimes Criminal Cases (H640-A/15)	Ethics	ADOPTED
H631	Managed Care – All Products Clauses (H642-A/15)	BSGA	ADOPTED
H632	Medical Procedure Patents (H643-A/15)	BFHP	ADOPTED
H633	Medicare Contractor Denial Letters (H644-A/15)	BSA	ADOPTED as AMENDED
H634	Osteopathic Medical Student, Resident, and Physician Mental Health (H646-A/15)	BEL	ADOPTED
H635	American Osteopathic Association (AOA) Osteopathic Manipulative Treatment (OMT) Coverage Determination Guidance (H647-A/15)	BSA	ADOPTED
H636	Access to Care – Network Adequacy and Coverage	BSGA	ADOPTED as AMENDED
H637	Addressing Fears and Barriers to Telemedicine Implementation and Alignment	MOA	ADOPTED as AMENDED
H638	Addressing Social Determinants of Health Through Data Collection and Improved Access to Social Services	SOMA	REFERRED

AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
Chicago, IL 60611
888.626.9262
osteopathic.org

SPECIAL SESSION OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
AD HOC - RESOLUTION ROSTER
WITHACTION

Res. No.	Resolution Title	Submitted By	Action
H639	Elimination of Prior Authorization and Step Therapy	MOA	NOT ADOPTED
H640	H623-A/18 Non-Physician Clinicians	BSGA	ADOPTED as AMENDED
H641	Marketing AOA Board Certification	AOCOPM	NOT ADOPTED
H642	Prior Authorization	BSA	ADOPTED
H643	Professional Liability Insurance Reform	BSGA	ADOPTED
H644	Re-Establishment of the Bureau of Osteopathic Specialty Societies (BOSS)	AOCOPM	NOT ADOPTED
H645	REFERRED RESOLUTION: H636-A/2019 Obesity Treatment Reimbursement in Primary Care	BSA	ADOPTED as AMENDED
H646	REFERRED RESOLUTION: H-615: Postpartum Depression	BSAPH	ADOPTED
H647	REFERRED SUNSET RESOLUTION: H-619 - A/2019: H624-A/14 Managed Care Plans – Service, Access and Costs in	BSA	ADOPTED
H648	Researching Patient Safety and Provider Qualifications	SOMA	ADOPTED as AMENDED
H649	Support the Bolstering of Veteran Health Administration Resources Through Provider Pay Reform	SOMA	ADOPTED
H650	Telemedicine; Reimbursement for	NYSOMS	ADOPTED as AMENDED

SUBJECT: H600-A/15 DISSEMINATION OF PUBLICATIONS IN OSTEOPATHIC RESEARCH

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H600-A/15 DISSEMINATION OF PUBLICATIONS IN OSTEOPATHIC RESEARCH

The American Osteopathic Association will widely disseminate publications, research, and evidence based medicine regarding Osteopathic Medicine and Osteopathic Manipulative Treatment (OMT) and its anatomical and physiological basis to the greater public via prominent, designated public information sites, social networking, public information releases, websites, and other media. 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H601-A/15 REDUCTION OF OSTEOPATHIC TRAINING POSITIONS IN POST-GRADUATE MEDICAL EDUCATION

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be SUNSET.

(Old language is crossed out and new language is in CAPS)

H601-A/15 REDUCTION OF OSTEOPATHIC TRAINING POSITIONS IN POST-GRADUATE MEDICAL EDUCATION

The American Osteopathic Association will work to create parity in reimbursement from the Centers for Medicare and Medicaid Services (CMS) for all osteopathic training to be equivalent to allopathic programs. 2015.

Explanatory Statement: Submitted by Author

The AOA no longer separately accredits graduate medical education programs.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED** *(for sunset)*

DATE: **October 13, 2020**

SUBJECT: H602-A/15 REIMBURSEMENT FOR PHYSICIAN TIME SPENT OBTAINING PRE-CERTIFICATION AND PRE-AUTHORIZATION

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be SUNSET.

(Old language is crossed out and new language is in CAPS)

H602-A/15 REIMBURSEMENT FOR PHYSICIAN TIME SPENT OBTAINING PRE-CERTIFICATION AND PRE-AUTHORIZATION

The American Osteopathic Association will include in its work plan investigation and recommendations for a framework for diagnostic and procedure coding, along with associated payment policies, for physician time spent obtaining required Medicare pre-certifications or pre-authorizations for those designated services or prescriptions and provide a template for use by state affiliates for third party payers within the jurisdiction of their state. 2015

Explanatory Statement: Submitted by Author:
The Bureau of Socioeconomic Affairs has submitted a resolution for consideration by the 2020 HOD which will merge this policy with several other existing policies to create one comprehensive policy addressing Prior Authorization.

Background Information: Provided by AOA Staff
Current AOA Policy:
H343-A/13 CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE FOR PRIOR AUTHORIZATION
H640-A/16 PRIOR AUTHORIZATION
H632-A/17 PRIOR AUTHORIZATION
H635-A/19 PRIOR AUTHORIZATION – PATIENT AUTHORIZATION

Prior HOD action on similar or same topic: H343-A/13 policy reaffirmed in 2013 (referred to BSA in 2018); H640-A/16 policy approved in 2016; H632-A/17 policy approved in 2017, H635-A/19 policy approved in 2019

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED** *(for sunset)*

DATE: **October 13, 2020**

SUBJECT: H604-A/15 PAY FOR PERFORMANCE

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H604-A/15 PAY FOR PERFORMANCE

In an effort to support the establishment of REASONABLE PAYMENT ~~appropriate pay-for-performance methodology~~ that will reflect the quality of care provided by physicians and improve patient health outcomes, the AOA adopts the following principles on quality reporting and pay-for-performance (2006; reaffirmed 2011; revised 2015).

1. THE AOA SUPPORTS THE ESTABLISHMENT OF QUALITY REPORTING AND/OR PAY-FOR-PERFORMANCE SYSTEMS WHOSE PRIMARY GOALS ARE TO IMPROVE THE HEALTH CARE AND HEALTH OUTCOMES OF PATIENTS. THE AOA BELIEVES THAT SUCH PROGRAMS SHOULD NOT BE BUDGET NEUTRAL. APPROPRIATE ADDITIONAL RESOURCES SHOULD SUPPORT IMPLEMENTATION AND REWARD PHYSICIANS WHO PARTICIPATE IN THE PROGRAMS AND DEMONSTRATE IMPROVEMENTS. THE AOA RECOMMENDS THAT ADDITIONAL FUNDING BE USED TO ESTABLISH BONUS PAYMENTS.
2. THE AOA BELIEVES THAT TO THE EXTENT POSSIBLE, PARTICIPATION IN QUALITY REPORTING AND PAY-FOR-PERFORMANCE PROGRAMS SHOULD BE VOLUNTARY AND PHASED-IN OVER AN APPROPRIATE TIME PERIOD. THE AOA ACKNOWLEDGES THAT FAILURE TO PARTICIPATE MAY DECREASE ELIGIBILITY FOR BONUS OR INCENTIVE-BASED PAYMENTS BUT FEELS STRONGLY THAT PHYSICIANS MUST BE AFFORDED THE OPTION OF NOT PARTICIPATING.
3. THE AOA RECOMMENDS THAT PHYSICIANS HAVE A CENTRAL ROLE IN THE ESTABLISHMENT AND DEVELOPMENT OF QUALITY STANDARDS. A SINGLE SET OF STANDARDS APPLICABLE TO ALL PHYSICIANS IS NOT ADVISABLE. INSTEAD, STANDARDS SHOULD BE DEVELOPED ON A SPECIALTY-BY-SPECIALTY BASIS, APPLYING THE APPROPRIATE RISK ADJUSTMENTS AND TAKING INTO ACCOUNT PATIENT COMPLIANCE. ADDITIONALLY, QUALITY STANDARDS SHOULD NOT BE ESTABLISHED OR UNNECESSARILY INFLUENCED BY PUBLIC AGENCIES OR PRIVATE SPECIAL INTEREST GROUPS WHO COULD GAIN BY THE ADOPTION OF CERTAIN STANDARDS. HOWEVER, THE AOA DOES SUPPORT THE ABILITY OF APPROPRIATE OUTSIDE GROUPS WITH ACKNOWLEDGED EXPERTISE TO ENDORSE DEVELOPED STANDARDS THAT MAY BE USED.

4. THE AOA DOES NOT SUPPORT THE EXCLUSIVE USE OF CLAIMS-BASED DATA IN QUALITY EVALUATION. INSTEAD, THE AOA SUPPORTS THE DIRECT AGGREGATION OF CLINICAL DATA BY PHYSICIANS. PHYSICIANS OR THEIR DESIGNATED ENTITY WOULD REPORT THIS DATA TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AND/OR OTHER PAYERS.

5. THE FEDERAL GOVERNMENT MUST ADOPT STANDARDS PRIOR TO THE IMPLEMENTATION OF ANY NEW HEALTH INFORMATION SYSTEM. SUCH STANDARDS MUST ENSURE INTEROPERABILITY BETWEEN PUBLIC AND PRIVATE SYSTEMS AND PROTECT AGAINST EXCLUSION OF CERTAIN SYSTEMS. INTEROPERABILITY MUST APPLY TO ALL PROVIDERS IN THE HEALTH CARE DELIVERY SYSTEM, INCLUDING PHYSICIANS, HOSPITALS, NURSING HOMES, PHARMACIES, PUBLIC HEALTH SYSTEMS, AND ANY OTHER ENTITIES PROVIDING HEALTH CARE OR HEALTH CARE RELATED SERVICES. THESE STANDARDS SHOULD BE ESTABLISHED AND IN PLACE PRIOR TO ANY COMPLIANCE REQUIREMENTS.

6. THE AOA ENCOURAGES THE FEDERAL GOVERNMENT TO REFORM EXISTING STARK LAWS IN ORDER TO ALLOW PHYSICIANS TO COLLABORATE WITH HOSPITALS AND OTHER PHYSICIANS IN THE PURSUIT OF ELECTRONIC HEALTH RECORDS (EHR) SYSTEMS WITHOUT FEAR OF PROSECUTION. THIS WILL PROMOTE WIDESPREAD ADOPTION OF EHR, EASE THE FINANCIAL BURDEN ON PHYSICIANS, AND ENHANCE THE EXCHANGE OF INFORMATION BETWEEN PHYSICIANS AND HOSPITALS LOCATED IN THE SAME COMMUNITY OR GEOGRAPHIC REGION.

7. THE AOA SUPPORTS THE ESTABLISHMENT OF PROGRAMS TO ASSIST ALL PHYSICIANS IN PURCHASING HEALTH INFORMATION TECHNOLOGY (HIT). THESE PROGRAMS MAY INCLUDE GRANTS, TAX-BASED INCENTIVES, AND BONUS PAYMENTS THROUGH THE MEDICARE PHYSICIAN PAYMENT FORMULA AS A WAY TO PROMOTE ADOPTION OF HIT IN PHYSICIAN PRACTICES. WHILE SMALL GROUPS AND SOLO PRACTICE PHYSICIANS SHOULD BE ASSISTED, PROGRAMS SHOULD NOT EXPRESSLY EXCLUDE LARGE GROUPS FROM PARTICIPATION.

8. THE AOA SUPPORTS THE ESTABLISHMENT OF PROGRAMS THAT ALLOW PHYSICIANS TO BE COMPENSATED FOR PROVIDING CHRONIC CARE MANAGEMENT SERVICES. FURTHERMORE, THE AOA DOES NOT SUPPORT THE ABILITY OF OUTSIDE VENDORS INDEPENDENT OF PHYSICIANS TO PROVIDE SUCH SERVICES.

9. THE AOA BELIEVES THAT PHYSICIANS WHO PARTICIPATE IN PAY FOR PERFORMANCE PROGRAMS HAVE THE RIGHT TO REVIEW, COMMENT, AND APPEAL ANY PERFORMANCE DATA.

10. THE AOA BELIEVES THAT PAY FOR PERFORMANCE PROGRAMS SHOULD INCLUDE MONITORING AND EVALUATION BY BOTH PAYORS AND PHYSICIAN ORGANIZATIONS TO IDENTIFY ELEMENTS THAT POSITIVELY AFFECT OUTCOMES.

11. THE AOA BELIEVES THAT PATIENT SATISFACTION MEASURES SHOULD BE LIMITED TO EASILY DEFINABLE MEASURES.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
The Committee inserted the Principles from the original policy H604-A/15 so they could be viewed during review by the House.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: H606-A/15 PROPER BADGE IDENTIFICATION OF EMPLOYEES IN A HOSPITAL SETTING

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad HOC Committee

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H606-A/15 PROPER BADGE IDENTIFICATION OF EMPLOYEES IN A HOSPITAL SETTING

The American Osteopathic Association encourages all healthcare providers and hospital employees to wear hospital-issued identification badges with clear delineation of their professional role and that they verbally introduce and identify themselves and their role in the patient's treatment process, with the overall goal of improving patient safety and patient communication. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H607-A/15 INTEROPERABILITY OF HEALTH INFORMATION TECHNOLOGY

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H607-A/15 INTEROPERABILITY OF HEALTH INFORMATION TECHNOLOGY

The American Osteopathic Association (AOA) supports A NEW RISK-BASED OVERSIGHT FRAMEWORK FOR CLINICAL SOFTWARE, DEVELOPED THROUGH A MULTI-STAKEHOLDER CONCENSUS-BASED PROCESS. THE FRAMEWORK SHOULD TAKE INTO ACCOUNT RISK RELATIVE TO INTENDED USE, COST/BENEFIT OF PROPOSED OVERSIGHT, AND THE PRINCIPLE OF SHARED RESPONSIBILITY. PATIENT SAFETY AND APPROPRIATE IMPROVEMENTS IN QUALITY, EFFECTIVENESS, AND EFFICIENCY OF CARE DELIVERY SHOULD BE PARAMOUNT. THIS FRAMEWORK SHOULD NOT CONFLICT WITH OR DUPLICATE THE MEDICAL DEVICE REGULATION FRAMEWORK. THE AOA DOES NOT SUPPORT DATA BE TREATED AS A MEDICAL DEVICE, REGARDLESS OF THE CATEGORY OF HEALTH IT ASSOCIATED WITH THE DATA. THE AOA SUPPORTS A NATIONAL NETWORK FOR REPORTING PATIENT SAFETY EVENTS AND OTHER INFORMATION VITAL TO PUBLIC HEALTH, WHERE DATA CAN BE ACCESSED, ANALYZED, AND COMMUNICATED IN A TIMELY MANNER. THE REGULATORY FRAMEWORK SHOULD PROMOTE ~~An open~~ interoperability ~~platform for health care delivery~~, in order for clinical information systems to capture and share quality, outcome, cost, AND PATIENT HEALTHCARE data. TO SUPPORT COORDINATED HEALTH CARE AND DATA ANALYTICS TO PROMOTE TRANSITION TO A VALUE-BASED HEALTHCARE SYSTEM. THE AOA SUPPORTS A COMMON DATA STRUCTURE THAT WILL ENABLE INTEROPERABILITY, SETTING A CLEAR COURSE OF ACTION, FEDERAL SUPPORT FOR AN EXCHANGE INFRASTRUCTURE, AND STANDARDS WHICH WILL MAKE IT EASIER TO SHARE INFORMATION SO PHYSICIANS AND PATIENTS CAN MAKE INFORMED DECISIONS.

The AOA will encourage public and private sector stakeholders to develop clinically driven, standardized products that are interoperable by design, do not require costly and time-consuming customization, and for which any upgrades or future needs can be integrated seamlessly without burdensome costs or system modifications. The AOA also supports standardization of prior authorization attachments to alleviate burden and reduce delays to care.

The AOA opposes vendors blocking health care professionals' ability to access, view, share, or transfer data.

The AOA supports policies and technologies that facilitate person-centered health care~~, not technology-centered healthcare and policies that include adequate positive incentives for the adoption of health information technology.~~

The AOA will remain vigilant about mitigating the level of administrative burden posed by existing and new government policies. 2015

Explanatory Statement: Submitted by Author

This policy merges with H603-A/19 titled REGULATION OF HEALTH INFORMATION TECHNOLOGY SOFTWARE and includes content provided by the Michigan Osteopathic Association. Upon approval of this resolution policy H603-19 will be sunset.

Background Information: Provided by AOA Staff

Current AOA Policy: H603-A/19 titled REGULATION OF HEALTH INFORMATION TECHNOLOGY SOFTWARE

Prior HOD action on similar or same topic: Policy reaffirmed as amended in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H612-A/15 GIFTS TO PHYSICIANS FROM INDUSTRY

SUBMITTED BY: Ethics Subcommittee

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Ethics Subcommittee recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H612-A/15 GIFTS TO PHYSICIANS FROM INDUSTRY
The American Osteopathic Association has adopted the following "Guide to Section 17 of the AOA Code of Ethics" as follows, and will distribute this information to students of osteopathic medicine and osteopathic physicians (1991, revised 1994, 1999, 2003; 2008; reaffirmed as amended 2015).

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H614-A/15 PHYSICIAN COMPETENCY RETESTING

SUBMITTED BY: Bureau of Osteopathic Specialists

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Osteopathic Specialists recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H614-A/15 PHYSICIAN COMPETENCY RETESTING

The American Osteopathic Association: (1) supports the mission of physician competency, the quality movement and patient safety through self-regulation mechanisms rather than through government mandated retesting for purposes of obtaining relicensure or for receiving payment under a health benefits program. (2) continue its voluntary efforts to address and promote physician competency through the teaching of core competencies at the predoctoral and postdoctoral levels, physician assessment through osteopathic continuous certification ~~**and its AOA Clinical Assessment Program (CAP)**~~. 1988; reaffirmed 1993; revised 1998, 2003; revised 2008; revised 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: H615-A/15 HEALTH PLAN COVERAGE OF TOBACCO CESSATION TREATMENT

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H615-A/15 HEALTH PLAN COVERAGE OF TOBACCO CESSATION TREATMENT
The American Osteopathic Association encourages all health plans to follow tobacco cessation recommendations of the Centers for Disease Control and Prevention (CDC) and encourages all health care plans to accept CPT, ~~ICD-9~~ and ICD-10 codes for tobacco use as legitimate codes for payment for services provided for these codes. 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H616-A/15 ENCOURAGING PATIENT PARTICIPATION IN THEIR HEALTH CARE

SUBMITTED BY: Bureau of Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H616-A/15 ENCOURAGING PATIENT PARTICIPATION IN THEIR HEALTH CARE

The American Osteopathic Association recommends that all insurance companies consider the establishment of a system for rewarding those patients who are trying to stay health as a means of decreasing the amount of money spent on health care. 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H617-A/15 FRIVOLOUS LIABILITY LAWSUITS

SUBMITTED BY: Bureau of Federal Health Programs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Federal Health Programs recommends that the following policy be SUNSET.

(Old language is crossed out and new language is in CAPS)

H617-A/15 - FRIVOLOUS LIABILITY LAWSUITS
The American Osteopathic Association (AOA) supports, as a component of comprehensive tort reform, the ability of physicians who are victims of frivolous lawsuits to recover all out of pocket expenses and lost income. 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author
A resolution is being submitted that combines this policy with H333-A/18. It will read as follows:

H333-A/18 PROFESSIONAL LIABILITY INSURANCE REFORM
The American Osteopathic Association continues support of professional liability insurance reform that includes the following ~~eight~~ principles: (1) limitations on non-economic damages – including provisions that afford states the opportunity to maintain or establish laws governing limitations on non-economic damages; (2) prohibiting "loss of chance", (3) periodic payment of future expenses or losses; (4) offsets for collateral sources; (5) joint and several liability reform; (6) limitations on attorney contingency fees; (7) establishment of uniform statutes of limitations; ~~and~~ (8) establishment of alternative professional liability insurance reforms which may include but are not limited to – health courts, non-binding arbitration and I'm sorry clauses; **AND (9) REIMBUSEMENT OF ALL OUT-OF-POCKET EXPENSES AND LOST INCOME FOR PHYSICIANS WHO ARE VICTIMS OF FRIVOLOUS LAWSUITS**. 1985, revised 1990, 1993, 1998, 2003, revised 2008; reaffirmed 2013, reaffirmed as amended 2018

Background Information: Provided by AOA Staff
Current AOA Policy: H333-A/18 PROFESSIONAL LIABILITY INSURANCE REFORM

Prior HOD action on similar or same topic: Policy reaffirmed as amended in 2018.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED** *(for sunset)*

DATE: **October 13, 2020**

SUBJECT: H618-A/15 PROVIDER TAX

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H618-A/15 PROVIDER TAX
The American Osteopathic Association opposes any effort by a state or the federal government to impose a provider tax of any type. 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H619-A/15 MEDICAID PAYMENT

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRM as AMENDED.

(Old language is crossed out and new language is in CAPS)

H619-A/15 MEDICAID PAYMENT

The American Osteopathic Association supports ~~**legislation to ESTABLISH MEDICAID-MEDICARE PAYMENT PARITY**~~ **THE EFFORTS IN EACH STATE TO UPHOLD THEIR OBLIGATION TO PAY PHYSICIANS AND HOSPITALS AT A FAIR AND EQUITABLE RATE FOR PROVIDING QUALITY CARE TO THE STATE'S MEDICAID RECIPIENTS**. 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
The resolution submitted to the Committee did not contain the original language. Once obtained the Committee felt the original language better conveyed the intent of the resolution. Editorial comment reimburse was changed to pay to align with AOA policy on not using the word reimburse.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: H620-A/15 LAY MIDWIVES

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H620-A/15 – LAY MIDWIVES
The American Osteopathic Association opposes the licensing of lay midwives and will continue providing support to affiliate societies in opposing state's efforts to license lay midwives. 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H621-A/15 MEDICAL MALPRACTICE JUDGMENTS REQUIRING REIMBURSEMENT OF MEDICARE PAYMENTS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H621-A/15 MEDICAL MALPRACTICE JUDGMENTS REQUIRING REIMBURSEMENT OF MEDICARE PAYMENTS

The American Osteopathic Association will seek an immediate reversal of the policy of the Centers of Medicare and Medicaid (CMS) requiring a payback of medical care rendered by a provider who has agreed to a malpractice settlement or received a judgment in a malpractice court. 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
The Committee would like a report back on what steps have been taken since adoption of this resolution and the outcome to determine this policy's relevance.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Council on Economic and Regulatory Affairs)*

DATE: **October 13, 2020**

SUBJECT: H622-A/15 ELECTRONIC HEALTH RECORDS – PHYSICIAN ASSISTANCE PROGRAMS FOR TRANSITION TO

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H622-A/15 **HEALTH INFORMATION TECHNOLOGY PHYSICIAN ~~ASSISTANCE PROGRAMS FOR TRANSITION TO ELECTRONIC HEALTH RECORDS~~ SUPPORT FOR ADOPTING INNOVATIVE ~~HEALTH INFORMATION TECHNOLOGY~~**

The American Osteopathic Association will continue ~~to work with state osteopathic associations~~ to ~~assist~~ SUPPORT solo practice physicians and small-group practices in the adoption of health information technology (HIT). THE AOA SUPPORTS INCENTIVES OR ENHANCED PAYMENTS FOR ADOPTION OF INNOVATIVE HIT THAT IMPROVES CARE DELIVERY, COORDINATION, AND VALUE. 2005; revised 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author:
This policy was combined with H616-A/19 titled FEDERAL HEALTH INFORMATION TECHNOLOGY INCENTIVES – AOA SUPPORT for broader HIT interoperability. Approval of this resolution would sunset H616-A/19.

Background Information: Provided by AOA Staff
Current AOA Policy: H616-A/19 titled FEDERAL HEALTH INFORMATION TECHNOLOGY INCENTIVES – AOA SUPPORT

Prior HOD action on similar or same topic: Policy reaffirmed in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: H624-A/15 PRESCRIPTION MEDICATIONS -- OVERRIDES FOR

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be SUNSET.

(Old language is crossed out and new language is in CAPS)

H624-A/15 PRESCRIPTION MEDICATIONS -- OVERRIDES FOR
The American Osteopathic Association support legislative efforts to: (1) decrease the hold time for physicians and staff for requesting approval from insurance pharmacy plans, (2) require insurance pharmacy plans to allow patients to continue receiving the medications for which they are prescribed and are in good control; and (3) make it easier for a physician to request an approval. 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author:
Submitted a new resolution for consideration by 2020 HOD titled PRIOR AUTHORIZATION which includes content that covers this topic.

Explanatory Statement: Reference Committee
The Committee believes this policy needs to remain active since the policy the Bureau of Socioeconomic Affairs/Council on Economic and Regulatory Affairs submitted for consideration for 2020 HOD (H642), which incorporated this policy, was not approved by the Committee.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H625-A/15 PEDIATRIC PSYCHIATRIC CARE HEALTH RECORDS

SUBMITTED BY: Bureau of Socioeconomic Affairs / Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs and Bureau on Scientific Affairs and Public recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H625-A/15 PEDIATRIC PSYCHIATRIC CARE ~~HEALTH RECORDS~~

The American Osteopathic Association supports the development of educational programs to assist primary care physicians to identify and initiate appropriate support of pediatric psychiatric care and encourages insurance providers to adequately reimburse counseling and psychiatric care deemed necessary by the patient's primary care physician. 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H626-A/15 ATTENTION DEFICIT DISORDER / ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD / ADHD)

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H626-A/15 ATTENTION DEFICIT DISORDER / ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD / ADHD)

The American Osteopathic Association urges insurance carriers to provide coverage for attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) patients by primary care physicians. 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H628-A/15 MEDICARE RECOVERY AUDIT CONTRACTORS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H628-A/15 MEDICARE RECOVERY AUDIT CONTRACTORS
The American Osteopathic Association will communicate to the Centers for Medicare & Medicaid Services (CMS) its concern about the Medicare Recovery Audit Contractors (RAC) payment methodology. 2005; revised 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
The Committee would like a report back on what steps have been taken regarding this policy and the outcome.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Council on Economic and Regulatory Affairs)*

DATE: **October 13, 2020**

SUBJECT: H629-A/15 MEDICARE LAW AND RULES

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau on Federal Health Program recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H629-A/15 MEDICARE LAW AND RULES
The American Osteopathic Association recommends that Medicare regulations that restrict a patient's freedom, as well as assess punitive damages to physicians, be challenged and that administrative burdens placed on both the patient and physician be reduced. 1995; revised 2000, 2005; reaffirmed 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
The Committee would like a report back with examples and steps that have been taken to address.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Bureau on Federal Health Programs)*

DATE: **October 13, 2020**

SUBJECT: H630-A/15 VETERANS ADMINISTRATION CREDENTIALING OF NON-PHYSICIAN PROVIDERS HEALTH RECORDS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H630-A/15 VETERANS ADMINISTRATION CREDENTIALING OF NON-PHYSICIAN PROVIDERS ~~HEALTH RECORDS~~

The American Osteopathic Association **(AOA)** supports the establishment of well-defined credentialing and privileging criteria within the Veterans Administration (VA) that prohibits non-physician providers with expanded scope of practice rights in a minority of states from demanding such privileges in the VA system and supports the establishment of a consistent requirement for the privileging of non-physician providers in the VA system. 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H631-A/15 TAX CREDITS FOR HEALTH PROFESSION SHORTAGE AREAS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H631-A/15 TAX CREDITS FOR HEALTH PROFESSION SHORTAGE AREAS

The American Osteopathic Association (AOA) supports the establishment of tax credits for physicians who practice full time in federally designated health professions shortage areas (HPSAs) or Medicare defined physician scarcity areas and federally and/or state designated underserved areas and urges that these tax credits be available, on a sliding scale, to physicians who provide services on a part-time basis in these communities. 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H632-A/15 OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) IN A PRE-PAID ENVIRONMENT –PAYMENT POLICIES FOR

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H632-A/15 OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) IN A PRE-PAID ENVIRONMENT –PAYMENT POLICIES FOR

The American Osteopathic Association will work to ensure that: (1) osteopathic manipulative treatment in any prepaid compensation model be recognized as a separate procedure; (2) osteopathic manipulative treatment as a procedure applied by fully-licensed physicians and surgeons be considered unique; and (3) osteopathic manipulative treatment in any prepaid compensation model be compensated as a special separate procedure, either by payment of additional capitation or on a fee-for-service basis without the need for prior authorization. 1995; revised 2000, 2005, 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H633-A/15 PRESCRIPTION OF DRUGS FOR OFF LABEL USES

SUBMITTED BY: Bureau of Federal Health Programs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Federal Health Programs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H633-A/15 PRESCRIPTION OF DRUGS FOR OFF LABEL USES
The American Osteopathic Association believes it is appropriate for physicians to prescribe approved drugs for uses not included in their official labeling when they can be supported as accepted medical practice. 1995; reaffirmed 2000, 2005, 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H635-A/15 NEWBORN AND INFANT HEARING SCREENS

SUBMITTED BY: Bureau of Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H635-A/15 NEWBORN AND INFANT HEARING SCREENS
The American Osteopathic Association supports adequate funding for universal hearing screening and intervention for newborns and infants. 1995; revised 2000, 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H636-A/15 MEDICARE PREVENTIVE MEDICAL SCREENING

SUBMITTED BY: Bureau of Federal and Health Programs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Federal and Health Programs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H636-A/15 MEDICARE PREVENTIVE MEDICAL SCREENING
The American Osteopathic Association supports coverage of Medicare recipients for routine preventive medical services. 1995; reaffirmed 2000, revised 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H637-A/15 CONFIDENTIALITY OF PATIENT RECORDS

SUBMITTED BY: Ethics Subcommittee

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Ethics Subcommittee recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H637-A/15 CONFIDENTIALITY OF PATIENT RECORDS
The American Osteopathic Association opposes invasion of privacy of the patient record by any unauthorized person or agency; and endorses reasonable programs which seek to protect patient/physician relationships and guarantee confidentiality of patient records. 1980; revised 1985, 1990, 1995; 2000, 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H638-A/15 DIABETICS CONFINED TO CORRECTIONAL INSTITUTIONS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H638-A/15 ~~DIABETICS~~ PERSONS WITH DIABETES CONFINED TO CORRECTIONAL INSTITUTIONS

The American Osteopathic Association supports the availability of American Diabetes Association (ADA) diabetic meals, beverages, and other diabetic interventions that follow ADA guidelines for all ~~diabetic inmates~~ IMPRISONED PERSONS WITH DIABETES, who are under the care of a licensed physician, and confined in correctional institutions. 2000, revised 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H639-A/15 DISCRIMINATION BY INSURERS

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau on Socioeconomic Affairs and Council on AOA Policy recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H639-A/15 DISCRIMINATION BY INSURERS

The American Osteopathic Association will actively pursue all reasonable avenues in support of its members who are discriminated against by insurance companies and excluded from participating in insurance programs; and in those instances where there is no due process to discuss and mediate the exclusions, the AOA will petition organizations to present their credentialing criteria and deselection criteria, and will use those resources at its disposal to help obtain a fair and equitable solution to the problem and to include due process in all cases. 1995; revised 2000, 2005; revised 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H640-A/15 EXECUTIONS IN CAPITAL CRIMES CRIMINAL CASES

SUBMITTED BY: Ethics Subcommittee

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Ethics Subcommittee recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H640-A/15 EXECUTIONS IN CAPITAL CRIMES CRIMINAL CASES
The American Osteopathic Association deems it an unethical act for any osteopathic physician to deliver or be required to deliver a lethal injection for the purpose of execution in capital crimes. 1995; revised 2000, reaffirmed 2005; 2010; [Editor's note: In 2015 this policy was referred to the Ethics Subcommittee].

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H642-A/15 MANAGED CARE – ALL PRODUCTS CLAUSES

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRM as AMENDED.

(Old language is crossed out and new language is in CAPS)

H642-A/15 MANAGED CARE – ALL PRODUCTS CLAUSES

The American Osteopathic Association and state osteopathic societies oppose the use of "all products/all products developed in the future" clauses in physician managed care contracts; actively opposes the use of any other clauses that may limit the ability of the physician to choose the plans in which he or she participates; ~~will educate its members on the potential risks of "all products/all products developed in the future" clauses and the importance of identifying such clauses in contracts prior to their signing~~; and supports both state and federal legislation as well as regulatory agency regulations and rulings to prohibit the use of "all products/all products developed in the future" clauses in physician managed care contracts. 2000, revised 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H643-A/15 MEDICAL PROCEDURE PATENTS

SUBMITTED BY: Bureau of Federal Health Program

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Federal Health Program recommends that the following policy be REAFFIRM.

(Old language is crossed out and new language is in CAPS)

H643-A/15 MEDICAL PROCEDURE PATENTS
The American Osteopathic Association (AOA) supports measures that restrict medical procedure patents. 1995; reaffirmed 2000, revised 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H644-A/15 MEDICARE CONTRACTOR DENIAL LETTERS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H644-A/15 MEDICARE CONTRACTOR DENIAL OF SERVICE LETTERS
The American Osteopathic Association calls upon the Centers for Medicare and Medicaid Services (CMS) to continue to involve osteopathic physicians in the development of screening parameters **FOR DENIAL OF SERVICES FOR** ~~**including**~~ osteopathic structural diagnoses and **OSTEOPATHIC** manipulative treatments. 1990; revised 1995, 2000, 2005; revised 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: H646-A/15 OSTEOPATHIC MEDICAL STUDENT, RESIDENT, AND PHYSICIAN MENTAL HEALTH

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Emerging Leaders recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H646-A/15 OSTEOPATHIC MEDICAL STUDENT, RESIDENT, AND PHYSICIAN MENTAL HEALTH

The American Osteopathic Association (AOA) will promote mental health awareness and provide osteopathic medical students, residents, and physicians with educational information on recognizing mental health issues among themselves and their colleagues. The AOA will work with the American Association of Colleges of Osteopathic Medicine, AOA State Divisional Societies, and Advocates for the American Osteopathic Association to reduce the stigma associated with mental illness to eliminate barriers to treatment while advocating for increasing the resources for care. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H647-A/15 AMERICAN OSTEOPATHIC ASSOCIATION (AOA) OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) COVERAGE DETERMINATION GUIDANCE

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H647-A/15 AMERICAN OSTEOPATHIC ASSOCIATION (AOA) OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) COVERAGE DETERMINATION GUIDANCE

The American Osteopathic Association (AOA) approves the attached policy as the standard guidelines for OMT coverage and encourages all public and private payers to refer to the AOA's policy when developing new policy or revising existing guidance for OMT coverage. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, access to health care relies upon both the availability of providers and the patients' ability to cover the costs of health care services; and

WHEREAS, comprehensive, high-quality health care often involves services from multiple providers across different specialties, often working in collaboration; and

WHEREAS, government regulators and insurance companies have a responsibility to ensure that plan networks have adequate numbers of providers available in-person to provide all necessary services in the beneficiary's area; now, therefore be it

RESOLVED, American Osteopathic Association (AOA) will advocate to ensure plan coverage by public and private payors for all medically necessary services in-person, within a reasonable distance/wait time for all plan beneficiaries; and be it further

RESOLVED, the AOA support state insurance commissioners **AND/OR OTHER APPROPRIATE REGULATORY AGENCIES** as the primary enforcers of network adequacy requirements.

Explanatory Statement: Submitted by Author:

H317-A/15 PATIENT ACCESS IN RURAL AREAS has been reviewed by the Bureau of State Government Affairs and it was determined that the content could be merged into **H635-A/16** ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE to create a more comprehensive, streamlined policy. We suggest that both **H317-A/15** and **H635-A/16** be deleted and replaced with this resolution. Relevant revised language from those resolutions has been included in this resolution:

H317-A/15 PATIENT ACCESS IN RURAL AREAS

~~The American Osteopathic Association supports policy on the state and federal levels that would require all managed care health plans to have reasonably placed network physicians and hospital access; if the distance is unreasonable, the plans should pay for out of network services at no additional cost to the patient.~~

H635-A/16 ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE

The American Osteopathic Association (AOA) will advocate ~~for public and private payors~~ **TO** ensur**E**~~ing~~ plan coverage BY PUBLIC AND PRIVATE PAYORS for all medically necessary services **IN-PERSON, WITHIN A REASONABLE DISTANCE/WAIT TIME FOR ALL PLAN** ~~regardless of availability within the service area of its~~ beneficiaries, and support~~ing~~ state ~~regulators~~ **INSURANCE COMMISSIONERS** as the primary enforcer**S** of network adequacy requirements.

Background Information: Provided by AOA Staff
Current AOA Policy:
H309-A/16 PATIENT ACCESS IN RURAL AREAS
H635-A/16 ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE

Prior HOD action on similar or same topic: H309-A/16 policy reaffirmed in 2016; H635-A/16 policy approved in 2016.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: ADDRESSING FEARS AND BARRIERS TO TELEMEDICINE IMPLEMENTATION AND ALIGNMENT

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, telemedicine is becoming a growing entity and option for healthcare services; and

WHEREAS, the potential convenience and lower costs of telemedicine may be highly attractive to patients; and

WHEREAS, many physicians have expressed concern that telemedicine could adversely affect the patient/physician relationship, quality of care, and/or patient safety; and

WHEREAS, appropriate oversight and regulations for telemedicine services are lacking; and

WHEREAS, inferior technology and network coverage can affect consistent services; and

WHEREAS, empowering a physician's ability to engage and implement telemedicine could increase revenue, practice marketing options, and enhance relationships with physician's existing patients; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) engage partner organizations to support understanding, training and implementation of telemedicine in physician offices; and, be it further

RESOLVED, that the AOA **BELIEVES THAT EVERY EFFORT SHOULD BE MADE TO ALLOW TELEMEDICINE SERVICES TO BE PROVIDED BY THE PATIENT'S ~~REGULAR~~ ATTENDING PHYSICIAN RATHER THAN BY PROVIERS NOT AFFILIATED WITH OR TO WHOME THE PATIENT HAS NOT BEEN REFERRED BY THE PATIENT'S PRIMARY CARE PHYSICIAN ~~engage in evaluating processes that help our physicians implement telemedicine in practices~~**.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: H601-A/17 TELEMEDICINE – AOA POLICY ON

Prior HOD action on similar or same topic: Policy approved as amended in 2017.

FISCAL IMPACT: $0
Finance Committee Explanatory Statement – The general provisions included in this resolution may be incorporated into the AOA's existing processes without additional fiscal impact. Activities undertaken through the educational, legislative and legal realms currently address evolving telemedicine issues as

warranted. Additional efforts would require shifting of resources, but without an expectation of additional expenditures at this time.

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: ADDRESSING SOCIAL DETERMINANTS OF HEALTH THROUGH DATA COLLECTION AND IMPROVED ACCESS TO SOCIAL SERVICES

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, equity in health and overall wellbeing is not simply determined by individual choices but based on life chances and the resources provided in the environment one is born into [1,2]; and

WHEREAS, consistent structural differences in social opportunities amongst the indigent compared to the affluent is as important to life expectancy and health outcomes as affordable access to medical treatment[1,2]; and

WHEREAS, the glaring inequality in freedom to live a thriving, healthy life can be balanced through concerted effort to reverse structural drivers including policies, economics, and living conditions to ensure a sustainable standard of health across all socioeconomic and cultural backgrounds[1,2]; and

WHEREAS, there is widespread support for screening tools to measure social determinants of health (SDoH) such as food insecurity, domestic violence, and housing quality that currently exist in clinical practice[3,4]; and

WHEREAS, implementation of comprehensive screening with adequate linked cooperation to local community resources was a noted barrier to practical use[3]; and

WHEREAS, the success of promising universal assessment tools, such as the Center for Medicare and Medicaid Services' Accountable Health Communities (AHC) Model, could be limited by inadequate funding, lack of hospital cooperation, and omission of essential social and behavioral measures [4,5]; and

WHEREAS, American Osteopathic Association (AOA) aims to promote public health and accentuate the distinctive philosophy of Osteopathic Medicine to treat the whole-person as affirmed by AOA Policy H406-A/17 and H300-A/18; and

WHEREAS, private sector organizations are working with national medical organizations through the Integrated Health Model Initiative (IHMI) to address the issue of SDoH systematically through the process of creating relevant ICD-10 codes related to "critical factors of patient well-being, such as employment, education, food, housing, access to transportation, and many other factors" which will trigger social services referrals[7]; and

WHEREAS, ICD-10-CM is an international classification of diseases that plays a fundamental role in health care delivery and payment policy, and it has recently been adapted in the United States to include clinical modification (CM) which expands implications to precise measuring, disease tracking, health care utilization, and quality of patient care

including codes "Z00-Z99" for factors influencing health status and contact with health services [6]; and

WHEREAS, projects exist that aim to improve screening, diagnosis, treatment, and planning by using technology to streamline data collection by defining a coded library of terms related to SDoH and use interoperability of electronic health systems to address individual patient needs more effectively[8]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) will adopt an official position that supports the use of ICD-10-CM codes regarding social determinants of health that mitigate challenges of physician referrals to social or government resources; and, be it further

RESOLVED, that the AOA support legislation that improves interoperability of electronic health records to reduce overall health care costs by improving communication between members of a care team, including social services; and, be it further

RESOLVED, that the AOA support a validated screening tool to identify patients influenced by social determinants of health.

Explanatory Statement: Submitted by Author:

Please note the use of "structural drivers" in line 7 refers to gender norms and values, economic participation, social exclusion, wealth distribution, education, civil rights, governance, public spending priorities, and macroeconomic conditions [1]. Further, note that the phrase "validated screening tool" referenced in line 51 indicates issuing a position of support for the creation of a standardized measurement of social determinants of health in individual patients that can be used across the nation, in any setting, and that has been authenticated to accurately assess patients at risk without any bias or skew towards certain demographics. This tool is indicated to be used at patient intake to identify individuals, such that the proper ICD-10 codes can be documented at the time of the encounter. Please be advised that the use of the term "support(s)" in the resolved statements is meant to indicate that SOMA and the AOA will use their judgement to promote the utilization of existing ICD-10 codes whether it be issuing a statement of support, lobbying for federal legislation relating to these codes, etc.

References

1. Commission on Social Determinants of Health (CSDH), Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. 2008, World Health Organization: Geneva.
2. U.S. Department of Health and Human Services. Healthy People 2020: Social Determinants. Retrieved October 1, 2019, from: https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Social-Determinants
3. Davidson KW, McGinn T. Screening for Social Determinants of Health: The Known and Unknown. JAMA. Published online August 29, 2019. doi:10.1001/jama.2019.1091
4. Thomas-Henkel, Caitlin. Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations. Center for Health Care Strategies, Inc. October 2017, from https://www.chcs.org/media/SDOH-Complex-Care-Screening-Brief-102617.pdf
5. Centers for Medicare and Medicaid Services. Accountable Health Communities Model. Retrieved March 1, 2020, from: https://innovation.cms.gov/initiatives/ahcm

6. Centers for Disease Control and Prevention: National Center for Health Statistics. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). Retrieved March 1, 2020, from https://www.cdc.gov/nchs/icd/icd10cm.htm#FY%202020%20release%20of%20ICD-10-CM
7. American Medical Association. (2019, April 2). UNH and the AMA collaborate to address access to better health [Press release]. Retrieved from https://www.ama-assn.org/press-center/press-releases/unh-and-ama-collaborate-address-access-better-health
8. Health Level Seven® International (HL7®). (2019, August 20). New HL7® FHIR® Accelerator Project Aims to Improve Interoperability of Social Determinants of Health Data [Press release]. Retrieved from http://www.hl7.org/documentcenter/public_temp_E229E04C-1C23-BA17-0C76A643D1AFCAB7/pressreleases/HL7_PRESS_20190820.pdf

Explanatory Statement: Reference Committee

The Committee feels this needs to be restructured due to lack of clarity and overlap with existing policy.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **REFERRED** *(to Student Osteopathic Medical Association)*

DATE: **October 13, 2020**

SUBJECT: ELIMINATION OF PRIOR AUTHORIZATION AND STEP THERAPY

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, US healthcare spending is significantly greater for administrative costs than other countries; and

WHEREAS, substantial costs to medical practices are required in order to process Prior Authorizations (PAs); and

WHEREAS, administrative burdens to healthcare providers concerning PAs have substantially increased thus leading to higher cost and delays to patient care and the related adverse outcomes resulting from delays or denials of patient care; and

WHEREAS, legislative attempts to address PA issues have focused on transparency, rather than addressing the barriers to timely patient care; and

WHEREAS, PA burdens in medical practice have increased significantly; and

WHEREAS, PA's and step therapy have been shown to lead to unnecessary hospitalizations and overall health care, cost as well as increased patient morbidity and mortality; now, therefore be it

RESOLVED, that the American Osteopathic Association advocate for elimination of prior authorizations as a third payor pre-requisite for the provision of quality health care in order to avoid harm and/or death due to delays in care.

Explanatory Statement: Submitted by Author
None provided.

Explanatory Statement: Reference Committee
Complete elimination of prior authorization and step therapy could result in improper utilization. The committee feels that H642, reviewed by this committee, can be used to help place guardrails on these practices.

Background Information: Provided by AOA Staff
Current AOA Policy:
H343-A/13 CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE FOR PRIOR AUTHORIZATION
H602-A/15 REIMBURSEMENT FOR PHYSICIAN TIME SPENT OBTAINING PRE-CERTIFICATION AND PRE-AUTHORIZATION
H640-A/16 PRIOR AUTHORIZATION
H632-A/17 PRIOR AUTHORIZATION
H635-A/19 PRIOR AUTHORIZATION – PATIENT AUTHORIZATION

Prior HOD action on similar or same topic: H343-A/13 policy reaffirmed in 2013 (referred to BSA in 2018); H602-A/15 policy approved in 2015; H640-A/16 policy approved in 2016; H632-A/17 policy approved in 2017, H635-A/19 policy approved in 2019

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 13, 2020**

SUBJECT: H623-A/18 NON-PHYSICIAN CLINICIANS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, the Bureau of State Government Affairs (BSGA) convened a workgroup to review the American Osteopathic Association's (AOA) Non-Physician Clinicians policy in light of the ongoing attempts by non-physician clinicians to independently practice medicine, despite wide variances in their education, training, and competency demonstration requirements (all of which fall short of the nationally standardized requirements for physicians); and,

WHEREAS, current AOA policy H623-A/18 NON-PHYSICIAN CLINICIANS~~,~~ supports either (undefined) "collaboration" or "supervision" by physicians, to ensure meaningful physician involvement and oversight in states that do not currently allow non-physician clinicians to practice independently; and

WHEREAS, it is the belief of the BSGA that the AOA should retain its current opposition to independent practice for non-physicians, **TO VOICE OPPOSITION TO THE ESTABLISHMENT OF EDUCATIONAL PROGRAMS TITLED "RESIDENCIES AND FELLOWSHIPS" FOR ADVANCED PRACTICE NURSES, PHYSICIAN ASSISTANTS, PHYSICAL THERAPISTS ~~AND OTHERS~~, AND** add support for regulating these professionals by state medical licensing boards in states that currently allow non-physician clinicians to practice independently by law, to ensure that they are being held to the same standards of care as physicians; now, therefore be it

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED AS AMENDED.

H623-A/18 NON-PHYSICIAN CLINICIANS The American Osteopathic Association has adopted the attached policy paper as its position on non-physician clinicians including appropriate onsite supervision. 2000, revised 2005; revised 2010; reaffirmed 2015; revised 2018

Policy Statement - 2018 NON-PHYSICIAN CLINICIANS

OVER THE COURSE OF THE PAST CENTURY, SCIENTIFIC AND TECHNOLOGICAL ADVANCEMENTS HAVE LED TO IMPROVEMENTS IN THE TREATMENT OF DISEASE AND STANDARDS OF PATIENT CARE. AS A RESULT, THE STANDARDIZED MEDICAL EDUCATION, SUPERVISED POSTGRADUATE ("RESIDENCY") TRAINING AND EXAMINATION SERIES THAT ~~The DO/MD~~ PHYSICIANS IN THE UNITED STATES ARE REQUIRED TO COMPLETE IN ORDER TO OBTAIN AN UNLIMITED MEDICAL LICENSE HAS INCREASED AS WELL. AT THE SAME TIME, HOWEVER, SOME STATES ARE CREATING LEGISLATIVE PATHWAYS TO INDEPENDENT MEDICAL PRACTICE FOR OTHER TYPES OF CLINICIANS, DESPITE THE ABSENCE

OF NATIONALLY STANDARDIZED EDUCATION, TRAINING AND TESTING PATHWAYS FOR THESE CLINICIAN GROUPS, OR EVIDENCE REGARDING PATIENT SAFETY OUTCOMES.

The current DO/MD medical model, IN WHICH MEDICAL STUDENTS AND RESIDENT PHYSICIANS ARE REQUIRED TO DEMONSTRATE THEIR ABILITY TO SAFELY PROVIDE CARE TO PATIENTS UNDER THE SUPERVISION OF FULLY LICENSED PHYSICIANS, LEADING TO GREATER AUTONOMY OVER TIME, has proven its ability to provide ~~professionals~~ PHYSICIANS with THE complete KNOWLEDGE AND SKILL BASE ~~medical education and training and testing~~ needed to ensure patient safety AND OPTIMIZE OUTCOMES. IN ADDITION, MOST STATES IMPOSE ADDITIONAL CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS, AND MANY PHYSICIANS ELECT TO UNDERGO RIGOROUS CERTIFYING BOARD EXAMINATIONS TO DEMONSTRATE EXCELLENCE IN A PARTICULAR SPECIALTY, WHICH HELPS TO ENSURE THAT PHYSICIANS REMAIN TRAINED TO PROVIDE THE CURRENT HIGHEST STANDARD OF PATIENT CARE OVER THE COURSE OF THEIR CAREERS.

Thus, it is appropriate that the practice of medicine and the quality of medical care ~~are~~ REMAIN the responsibility of ~~properly licensed~~ physicians, WHO ARE THE ONLY CLINICIAN GROUP PROPERLY TRAINED, LICENSED AND REGULATED ACCORDING TO UNIFORM LAWS GOVERNING MEDICAL LICENSURE IN THE UNITED STATES. The American Osteopathic Association (AOA) ~~further~~ VALUES THE UNIQUE TRAINING AND CONTRIBUTIONS OF ALL MEMBERS OF THE PATIENT CARE TEAM, AND supports the concept of uniform licensure pathways for ~~non-physician~~ALL clinician GROUPS, based upon scope of practice. THE AOA~~It~~ FURTHER SUPPORTS APPROPRIATE PHYSICIAN INVOLVEMENT IN PATIENT CARE PROVIDED BY NON-PHYSICIAN CLINICIANS, AND opposes any legislation or regulations which would authorize the independent practice of medicine by an individual who has not completed the state's requirements for physician licensure.

As non-physician clinicians continue to seek wider roles, public policy dictates THAT patient safety and proper patient care should be foremost in mind when the issues encompassing expanded practice rights for non-physician clinicians – autonomy, scopes of practice, prescriptive rights, liability and reimbursement, among others – are addressed.

A. **Patient Safety.** The AOA supports the "team" approach to medical care, with the physician as the leader of that team. The AOA further supports the position that patients should be made clearly aware at all times whether they are being treated by a non-physician clinician or a physician. The AOA recognizes the growth of non-physician clinicians and supports their rights to practice with appropriate physician involvement within the scope of ~~the~~ relevant state statutes.

B. **Independent Practice.** It is the AOA's position that roles within the "team" framework must be clearly defined, through established STATE-LEVEL SUPERVISORY protocols and signed agreements, so physician involvement in patient care is sought when a patient's case dictates AND PATIENTS CAN REST ASSURED THAT PHYSICIAN INVOLVEMENT IN THEIR CARE WILL REMAIN THE SAME REGARDLESS OF PRACTICE SETTING WITHIN THE

STATE. ~~The AOA feels nonphysician clinician professions that have traditionally been under the supervision of physicians must retain physician involvement in patient care. Those non-physician clinician professions that have traditionally remained independent of physicians must involve physicians in patient care when warranted.~~ FURTHER, a~~A~~ll non-physician clinicians must refer a patient to a physician when the patient's condition is beyond the non-physician clinician's scope of education, training or expertise.

C. Liability. The AOA endorses the view that physician liability for non-physician clinician actions should be reflective of the quality AND DEGREE of supervision being provided and should not exonerate the non-physician clinician from liability. It is the AOA's position that non-physician clinicians ~~acting~~ PROVIDING CARE IN INDEPENDENT PRACTICE STATES ~~autonomously of physicians~~ should be REGULATED AND DISCIPLINED BY THE ENTITIES RESPONSIBLE FOR REGULATING AND DISCIPLINING PHYSICIANS (I.E. STATE MEDICAL BOARDS), TO ENSURE THAT ALL CLINICIANS WHO ARE INDEPENDENTLY PRACTICING MEDICINE ARE held to the SAME STANDARD OF CARE AND THE equivalent degree of liability ~~as that of a physician~~. ~~Within this independent practice framework,~~TO THAT END, the AOA ~~further~~ ALSO believes that non-physician clinicians should be required to obtain EQUIVALENT malpractice insurance ~~in those states that currently require~~TO physicians IN STATES THAT CURRENTLY REQUIRE PHYSICIANS to possess malpractice insurance.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: H623-A/18 NON-PHYSICIAN CLINICIANS

Prior HOD action on similar or same topic: Policy approved as amended in 2018.

Fiscal Impact: $0

ACTION TAKEN **ADOPTED as AMENDED**

DATE **October 13, 2020**

SUBJECT: H623-A/18 NON-PHYSICIAN CLINICIANS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, the Bureau of State Government Affairs (BSGA) convened a workgroup to review the American Osteopathic Association's (AOA) Non-Physician Clinicians policy in light of the ongoing attempts by non-physician clinicians to independently practice medicine, despite wide variances in their education, training, and competency demonstration requirements (all of which fall short of the nationally standardized requirements for physicians); and,

WHEREAS, current AOA policy H623-A/18 NON-PHYSICIAN CLINICIANS~~,~~ supports either (undefined) "collaboration" or "supervision" by physicians, to ensure meaningful physician involvement and oversight in states that do not currently allow non-physician clinicians to practice independently; and

WHEREAS, it is the belief of the BSGA that the AOA should retain its current opposition to independent practice for non-physicians, **TO VOICE OPPOSITION TO THE ESTABLISHMENT OF EDUCATIONAL PROGRAMS TITLED "RESIDENCIES AND FELLOWSHIPS" FOR ADVANCED PRACTICE NURSES, PHYSICIAN ASSISTANTS, PHYSICAL THERAPISTS ~~AND OTHERS~~, AND** add support for regulating these professionals by state medical licensing boards in states that currently allow non-physician clinicians to practice independently by law, to ensure that they are being held to the same standards of care as physicians; now, therefore be it

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED AS AMENDED.

H623-A/18 NON-PHYSICIAN CLINICIANS The American Osteopathic Association has adopted the attached policy paper as its position on non-physician clinicians including appropriate onsite supervision. 2000, revised 2005; revised 2010; reaffirmed 2015; revised 2018

Policy Statement - 2018 NON-PHYSICIAN CLINICIANS

OVER THE COURSE OF THE PAST CENTURY, SCIENTIFIC AND TECHNOLOGICAL ADVANCEMENTS HAVE LED TO IMPROVEMENTS IN THE TREATMENT OF DISEASE AND STANDARDS OF PATIENT CARE. AS A RESULT, THE STANDARDIZED MEDICAL EDUCATION, SUPERVISED POSTGRADUATE ("RESIDENCY") TRAINING AND EXAMINATION SERIES THAT ~~The DO/MD~~ PHYSICIANS IN THE UNITED STATES ARE REQUIRED TO COMPLETE IN ORDER TO OBTAIN AN UNLIMITED MEDICAL LICENSE HAS INCREASED AS WELL. AT THE SAME TIME, HOWEVER, SOME STATES ARE CREATING LEGISLATIVE PATHWAYS TO INDEPENDENT MEDICAL PRACTICE FOR OTHER TYPES OF CLINICIANS, DESPITE THE ABSENCE

OF NATIONALLY STANDARDIZED EDUCATION, TRAINING AND TESTING PATHWAYS FOR THESE CLINICIAN GROUPS, OR EVIDENCE REGARDING PATIENT SAFETY OUTCOMES.

The current DO/MD medical model, IN WHICH MEDICAL STUDENTS AND RESIDENT PHYSICIANS ARE REQUIRED TO DEMONSTRATE THEIR ABILITY TO SAFELY PROVIDE CARE TO PATIENTS UNDER THE SUPERVISION OF FULLY LICENSED PHYSICIANS, LEADING TO GREATER AUTONOMY OVER TIME, has proven its ability to provide ~~professionals~~ PHYSICIANS with THE complete KNOWLEDGE AND SKILL BASE ~~medical education and training and testing~~ needed to ensure patient safety AND OPTIMIZE OUTCOMES. IN ADDITION, MOST STATES IMPOSE ADDITIONAL CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS, AND MANY PHYSICIANS ELECT TO UNDERGO RIGOROUS CERTIFYING BOARD EXAMINATIONS TO DEMONSTRATE EXCELLENCE IN A PARTICULAR SPECIALTY, WHICH HELPS TO ENSURE THAT PHYSICIANS REMAIN TRAINED TO PROVIDE THE CURRENT HIGHEST STANDARD OF PATIENT CARE OVER THE COURSE OF THEIR CAREERS.

Thus, it is appropriate that the practice of medicine and the quality of medical care ~~are~~ REMAIN the responsibility of ~~properly licensed~~ physicians, WHO ARE THE ONLY CLINICIAN GROUP PROPERLY TRAINED, LICENSED AND REGULATED ACCORDING TO UNIFORM LAWS GOVERNING MEDICAL LICENSURE IN THE UNITED STATES. The American Osteopathic Association (AOA) ~~further~~ VALUES THE UNIQUE TRAINING AND CONTRIBUTIONS OF ALL MEMBERS OF THE PATIENT CARE TEAM, AND supports the concept of uniform licensure pathways for ~~non-physician~~ALL clinician GROUPS, based upon scope of practice. THE AOA~~It~~ FURTHER SUPPORTS APPROPRIATE PHYSICIAN INVOLVEMENT IN PATIENT CARE PROVIDED BY NON-PHYSICIAN CLINICIANS, AND opposes any legislation or regulations which would authorize the independent practice of medicine by an individual who has not completed the state's requirements for physician licensure.

As non-physician clinicians continue to seek wider roles, public policy dictates THAT patient safety and proper patient care should be foremost in mind when the issues encompassing expanded practice rights for non-physician clinicians – autonomy, scopes of practice, prescriptive rights, liability and reimbursement, among others – are addressed.

A. **Patient Safety.** The AOA supports the "team" approach to medical care, with the physician as the leader of that team. The AOA further supports the position that patients should be made clearly aware at all times whether they are being treated by a non-physician clinician or a physician. The AOA recognizes the growth of non-physician clinicians and supports their rights to practice with appropriate physician involvement within the scope of ~~the~~ relevant state statutes.

B. **Independent Practice.** It is the AOA's position that roles within the "team" framework must be clearly defined, through established STATE-LEVEL SUPERVISORY protocols and signed agreements, so physician involvement in patient care is sought when a patient's case dictates AND PATIENTS CAN REST ASSURED THAT PHYSICIAN INVOLVEMENT IN THEIR CARE WILL REMAIN THE SAME REGARDLESS OF PRACTICE SETTING WITHIN THE

STATE. ~~The AOA feels nonphysician clinician professions that have traditionally been under the supervision of physicians must retain physician involvement in patient care. Those non-physician clinician professions that have traditionally remained independent of physicians must involve physicians in patient care when warranted.~~ FURTHER, a~~A~~ll non-physician clinicians must refer a patient to a physician when the patient's condition is beyond the non-physician clinician's scope of education, training or expertise.

C. Liability. The AOA endorses the view that physician liability for non-physician clinician actions should be reflective of the quality AND DEGREE of supervision being provided and should not exonerate the non-physician clinician from liability. It is the AOA's position that non-physician clinicians ~~acting~~ PROVIDING CARE IN INDEPENDENT PRACTICE STATES ~~autonomously of physicians~~ should be REGULATED AND DISCIPLINED BY THE ENTITIES RESPONSIBLE FOR REGULATING AND DISCIPLINING PHYSICIANS (I.E. STATE MEDICAL BOARDS), TO ENSURE THAT ALL CLINICIANS WHO ARE INDEPENDENTLY PRACTICING MEDICINE ARE held to the SAME STANDARD OF CARE AND THE equivalent degree of liability ~~as that of a physician~~. ~~Within this independent practice framework,~~TO THAT END, the AOA ~~further~~ ALSO believes that non-physician clinicians should be required to obtain EQUIVALENT malpractice insurance ~~in those states that currently require~~TO physicians IN STATES THAT CURRENTLY REQUIRE PHYSICIANS to possess malpractice insurance.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: H623-A/18 NON-PHYSICIAN CLINICIANS

Prior HOD action on similar or same topic: Policy approved as amended in 2018.

Fiscal Impact: $0

ACTION TAKEN **ADOPTED as AMENDED**

DATE **October 13, 2020**

SUBJECT: MARKETING AOA BOARD CERTIFICATION

SUBMITTED BY: American Osteopathic College of Occupational and Preventive Medicine

REFERRED TO: Ad Hoc Committee

WHEREAS, the American Osteopathic Association (AOA) has deeming authority from the U.S. Department of Education to certify physicians; and

WHEREAS, AOA board certified physicians have historically been supportive and involved members of the AOA and its divisional societies; and

WHEREAS, the AOA, and its state associations' and specialty colleges', collectively known as divisional societies, health and viability will be strengthened by having many early career physicians sit for AOA examinations; and

WHEREAS, graduates of Accreditation Council of Graduate Medical Education (ACGME) programs must be informed of and provided reasons for pursuing AOA board certification; and

WHEREAS, the eighteen (18) AOA certifying boards depend upon item-writers who are overwhelmingly practicing physicians; and

WHEREAS, the AOA internally uses the tag line "*Practicing Physicians Certifying Practicing Physicians*"; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) implement a branding campaign for its specialty certifying boards to include incorporating the tag line "*Practicing Physicians Certifying Practicing Physicians*" on all AOA certifying boards webpages and letterhead; and, be it further

RESOLVED, that the AOA develop and broadly distribute a one-page info sheet targeting Graduate Medical Education (GME) sponsoring institutions, program directors, postdoctoral trainees, and board-eligible physicians; and, be it further

RESOLVED that the info sheet shall incorporate the tag line "*Practicing Physicians Certifying Practicing Physicians*" and discuss AOA certification in terms of relevance of exam to practice, affordability, value, convenience and ease of maintenance.

Explanatory Statement: Submitted by Author:

Potential candidates must be provided with reasons for pursuing AOA Board Certification: distinctiveness, value, relevance of exam to practice, affordability, convenience and ease of maintenance.

With ease of electronic communication and website branding, this resolution can be implemented with low costs and may help to expand our customer base and thus drive revenues to the certifying boards, specialty colleges, and the AOA.

The following Divisional Societies have endorsed this resolution:

- American Academy of Osteopathy
- American College of Osteopathic Family Physicians
- American College of Osteopathic Internists
- American College of Osteopathic Obstetricians & Gynecologists
- American College of Osteopathic Pediatricians
- American Osteopathic Academy of Addiction Medicine
- American Osteopathic Academy of Orthopedics
- American Osteopathic Academy of Sports Medicine
- American Osteopathic College of Dermatology
- American Osteopathic College of Occupational and Preventive Medicine
- American Osteopathic Colleges of Ophthalmology and Otolaryngology – Head and Neck Surgery
- American Osteopathic College of Pathologists

Explanatory Statement: Reference Committee
This policy conflicts with marketing campaigns and efforts recently started by the AOA.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: Up to $59,500 in additional expense.
The additional expenses incurred if the AOA pursued this resolution would consist of the cost of disposing current letterhead and business cards and the estimated costs of reprinting letterhead and business cards of $10,500, and estimated costs for rebranding between $16,500 and $49,000 at $165 per hour. Rebranding could be from 100 to 300 hours including 30-40 hours for content and design work by AOA staff. The range of additional expenses would be between $27,000 and $59,500.

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 13, 2020**

SUBJECT: PRIOR AUTHORIZATION

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, prior authorization (PA) results in care delays and adverse events, with a recent American Medical Association survey finding that 91% of physicians report care delays associated with PA and 28% report that PA has led to serious adverse events for their patients[1]; and

WHEREAS, prior authorization increases administrative burden for physicians with 86% of physicians citing high level of burden associated with PA requirements; and

WHEREAS, the American Osteopathic Association has numerous policies relating to PA and the 2019 House of Delegates directed the Bureau of Socioeconomic Affairs to unify policies into a comprehensive policy statement; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) adopts the following policy and principles statement on prior authorization; and be it further

RESOLVED, the AOA will merge policies H343-A/13, H602-A/15; H632-A/17, H635-A/19, H637-A/19, and H640-A/16.

Prior Authorization

Prior authorization requirements have been found to result in care delays that place patients at risk and to increase provider burden[2]. In order to ensure that prior authorization is implemented in an appropriate manner that minimizes burden and risk, the AOA believes that implementation of PA by payers and pharmacy benefit managers should abide by the following principles.

- Prior authorizations should be clinically relevant, evidence-based, transparent, and as minimally intrusive on the physician, medical staff, and patient as possible.
- Prior authorization programs that negatively impact access to care, delay treatment, result in abandonment, increase cost of care and administrative costs, do not align with recognized clinical practice guidelines, or have a negative impact on quality of care or outcomes should be discontinued.
- Payors should appropriately compensate providers for complying with utilization review.
- Prior authorization request forms should be standardized and electronic whenever feasible to promote procedural uniformity and reduce administrative burden.
- Allow continuation of medications already being administered or prescribed when a patient changes health plans and not allow changes without discussion and approval of the ordering physician.

[1] American Medical Association. "2018 AMA Prior Authorization (PA) Physician Survey".
[2] American Medical Association. "2018 AMA Prior Authorization (PA) Physician Survey".

- Providers should be notified of changes to prior authorization requirements at least 45 days prior to change.
- Payors and Plans should be required to report a list of services and prescription medications subject to prior authorization and corresponding denial, delay, and approval rates.
- Prior authorization requirements should be minimized as much as possible and eliminate the application of prior authorization to services and prescription medications that are routinely approved
- There should be an easily accessible and responsive direct communication tool to resolve conflicts between health plans and ordering physicians

As part of its efforts to advocate for these principles and ensure their incorporation into policy, the AOA will advocate for legislation and regulatory changes that would require payers and pharmacy benefit managers to:

- Disclose in sales, promotional materials and advertising that their products utilize a prior authorization process which may result in a delay in or denial of diagnosis and or treatment which may be detrimental to the patient's health or well-being;
- Consider a physician's attestation of clinical diagnosis or order sufficient documentation of medical necessity for durable medical equipment;
- Include in contracts with healthcare providers hold harmless clauses that indemnify healthcare providers against financial loss due to injury to a patient as a result of the payor's failure or refusal to grant a prior authorization request in a timely manner;
- Provide appropriate notice to patients and physicians when formulary and benefit changes are made;
- Include a correct phone number and web address on the patient identification card for initiating the prior authorization process; Make all forms used in the prior authorization process readily available to healthcare providers, including EMR templates;
- Publish and make available to the public all requirements for prior authorization and follow those published policies;
- Provide sufficient knowledgeable staff to ensure that healthcare providers are able to contact medical claims payers and pharmacy benefit managers without average hold times exceeding 10 minutes;
- Compensate medical practices and healthcare providers for the cost of time spent on inappropriately denied PA requests; and
- To identify and hold accountable the payor's medical director/claim adjudicator for the results of their decisions.

Explanatory Statement: Submitted by Author

Upon approval of this resolution the policies noted in the last resolved statement will be sunset.

Background Information: Provided by AOA Staff

Current AOA Policy:

H343-A/13 CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE FOR PRIOR AUTHORIZATION

H602-A/15 REIMBURSEMENT FOR PHYSICIAN TIME SPENT OBTAINING PRE-CERTIFICATION AND PRE-AUTHORIZATION

H640-A/16 PRIOR AUTHORIZATION
H632-A/17 PRIOR AUTHORIZATION
H635-A/19 PRIOR AUTHORIZATION – PATIENT AUTHORIZATION

Prior HOD action on similar or same topic: H343-A/13 policy reaffirmed in 2013 (referred to BSA in 2018); H602-A/15 policy approved in 2015; H640-A/16 policy approved in 2016; H632-A/17 policy approved in 2017, H635-A/19 policy approved in 2019

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: PROFESSIONAL LIABILITY INSURANCE REFORM

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, the current state of the legal system imposes great costs on the U.S. health care system and society in general by forcing physicians to maintain costly amounts of professional liability insurance; and

WHEREAS, these costs may ultimately be borne by patients through increased prices or through the loss of solo/small group practices in rural and underserved areas, where physicians may be unable to afford the cost of this insurance; and

WHEREAS, this legal system incentivizes physicians to practice defensive medicine to protect themselves from litigation, and discourages some physicians from pursuing riskier specialties such as obstetrics, even though specialists in these areas are needed; now, therefore be it

RESOLVED, that the American Osteopathic Association continues support of professional liability insurance reform that includes the following principles:

1) limitations on non-economic damages - including provisions that afford states the opportunity to maintain or establish laws governing limitations on non-economic damages;
2) prohibiting "loss of chance" liability;
3) periodic payment of future expenses or losses;
4) offsets for collateral sources;
5) joint and several liability reform;
6) limitations on attorney contingency fees;
7) establishment of uniform statutes of limitations;
8) establishment of alternative professional liability insurance reforms which may include but are not limited to – health courts, non-binding arbitration and "I'm sorry" clauses; and
9) reimbursement of all out-of-pocket expenses and lost income for physicians who are victims of frivolous lawsuits.

and, be it further

RESOLVED, that upon approval, AOA policies H617-A/15 FRIVOLOUS LIABILITY LAWSUITS and H333-A/18 PROFESSIONAL LIABILITY INSURANCE REFORM be sunset.

Explanatory Statement: Submitted by Author

H617-A/15 FRIVOLOUS LIABILITY LAWSUITS has been reviewed by the Bureau of State Government Affairs and it was determined that the content should be merged into **H333-A/18** PROFESSIONAL LIABILITY INSURANCE REFORM to create a more comprehensive, streamlined

policy. We suggest that both **H617-A/15** and **H333-A/18** be deleted and replaced with this resolution. Relevant revised language from those resolutions has been included in this resolution:

H617-A/15 FRIVOLOUS LIABILITY LAWSUITS
~~The American Osteopathic Association (AOA) supports, as a component of comprehensive tort reform, the ability of physicians who are victims of frivolous lawsuits to recover all out of pocket expenses and lost income.~~

H333-A/18 PROFESSIONAL LIABILITY INSURANCE REFORM
The American Osteopathic Association continues support of professional liability insurance reform that includes the following ~~eight~~ principles: (1) limitations on non-economic damages – including provisions that afford states the opportunity to maintain or establish laws governing limitations on non-economic damages; (2) prohibiting "loss of chance", (3) periodic payment of future expenses or losses; (4) offsets for collateral sources; (5) joint and several liability reform; (6) limitations on attorney contingency fees; (7) establishment of uniform statutes of limitations; ~~and~~ (8) establishment of alternative professional liability insurance reforms which may include but are not limited to – health courts, non-binding arbitration and I'm sorry clauses**; AND (9) REIMBUSEMENT OF ALL OUT-OF-POCKET EXPENSES AND LOST INCOME FOR PHYSICIANS WHO ARE VICTIMS OF FRIVOLOUS LAWSUITS.**

Background Information: Provided by AOA Staff
Current AOA Policy:
H617-A/15 FRIVOLOUS LIABILITY LAWSUITS
H333-A/18 PROFESSIONAL LIABILITY INSURANCE REFORM

Prior HOD action on similar or same topic: H617-A/15 policy approved in 2015; H333-A/18 policy approved in 2018.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: RE-ESTABLISHMENT OF THE BUREAU OF OSTEOPATHIC SPECIALTY SOCIETIES (BOSS)

SUBMITTED BY: American Osteopathic College of Occupational and Preventive Medicine

REFERRED TO: Ad Hoc Committee

WHEREAS, the American Osteopathic Association's (AOA) Bureau of Osteopathic Specialty Societies (BOSS), existed to allow for elected representatives from each of the specialty colleges to assemble to discuss AOA policy proposals and their impact on the Specialty Colleges; and

WHEREAS, other AOA Bureaus, Councils and Committees were able to refer matters to the BOSS for comment and refinement; and

WHEREAS, the BOSS was discontinued without provision of an alternative structure to ensure that specialty college elected leaders continued to have a vehicle for collaborative discernment on matters affecting their members; and

WHEREAS, the AOA Council on Osteopathic Continuing Medical Education (COCME), recently asked the Bureau of Osteopathic Specialists (BOS), the Bureau representing the AOA's Specialty Certifying Boards, to weigh in on proposed changes to CME requirements, including the tracking of specialty credits; however, the specialty colleges had no venue or opportunity to provide input; and

WHEREAS, sweeping changes to CME requirements and the tracking of specialty credits impact CME attendance at specialty college events and have significant fiscal impact on divisional societies, organized elements within the AOA structure should exist to solicit debate and support among key constituent groups, including the specialty college elected leaders; and

WHEREAS, since the disbandment of BOSS, the profession has gained additional expertise, experience and competence meeting in a virtual environment, the BOSS can now be re-implemented with very little fiscal impact to the AOA; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Specialty Societies (BOSS) be re-established, whose membership is comprised of one elected representative from each specialty society; and, be it further

RESOLVED, that the American Osteopathic Association (AOA) host at least two meetings per year: one prior to the AOA Mid-Year Board of Trustees meeting and the other prior to the Annual Business Meeting; as well as other times as requested by the BOSS; and, be it further

RESOLVED that the AOA can organize these meetings in a virtual or hybrid environment, in conjunction with the AOA Mid-Year Board of Trustees meeting and the Annual Business Meeting, to minimize the fiscal impact to the AOA and the specialty colleges.

Explanatory Statement: Submitted by Author
The Bureau of Osteopathic Specialty Societies (BOSS) enable elected leaders of the specialty colleges to come together to discuss a myriad of issues:

- Proposed AOA Board and House resolutions
- Joint responses to public comment periods from other AOA Bureaus, Councils and Committees
- Joint responses to public comment periods from the ACGME, COCA, and various federal government agencies (HRSA, MEDPAC, CMS, etc.)
- Advocacy for needed revisions to ACGME Common Program requirements
- Collaboration on common issues, such as student chapters, supporting of transitions from medical school to postdoctoral training
- Tracking of and service to postdoctoral trainees
- Joint CME programming and planning

The following divisional societies have endorsed this resolution:

- American Academy of Osteopathy
- American College of Osteopathic Family Physicians
- American College of Osteopathic Emergency Physicians
- American College of Osteopathic Obstetricians & Gynecologists
- American College of Osteopathic Pediatricians
- American College of Osteopathic Surgeons
- American Osteopathic Academy of Addiction Medicine
- American Osteopathic Academy of Sports Medicine
- American Osteopathic Association of Prolotherapy Regenerative Medicine
- American Osteopathic College of Anesthesiologists
- American Osteopathic College of Dermatology
- American Osteopathic College of Occupational and Preventive Medicine
- American Osteopathic Colleges of Ophthalmology and Otolaryngology – Head and Neck Surgery
- American Osteopathic College of Pathologists

Explanatory Statement: Reference Committee
AOA has just completed a systematic review and restructuring of its bureaus, councils, and committees. The AOA has also updated affiliate agreements with their input. This policy would be counterproductive to the AOA's recent efforts that it has undertaken in collaboration with affiliates.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **NOT ADOPTED**

DATE: **October 13, 2020**

SUBJECT: REFERRED RESOLUTION: H636-A/2019 OBESITY TREATMENT REIMBURSEMENT IN PRIMARY CARE

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, the AOA House of Delegates (HOD) referred resolution H-636-A/2019 titled OBESITY TREATMENT REIMBURSEMENT IN PRIMARY CARE submitted by the Michigan Osteopathic Association; and

WHEREAS, the HOD requested the Bureau of Socioeconomic Affairs "review the feasibility of obtaining payment for the treatment of obesity as a primary diagnosis and whether new CPT and diagnosis codes need to be created for payment purposes"; now, therefore be it

RESOLVED, that resolution H-636-A/2019 titled OBESITY TREATMENT REIMBURSEMENT IN PRIMARY CARE, be ADOPTED as amended

RES. NO. H-636 - A/2019

SUBJECT: OBESITY TREATMENT REIMBURSEMENT IN PRIMARY CARE

WHEREAS, the prevalence of obesity was 39.8% and affected about 93.3 million of US adults in 2015~2016[1]; and

WHEREAS, Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer that are some of the leading causes of preventable, premature death; and

WHEREAS, ensuring physician reimbursement for obesity treatment should be a priority to reduce morbidity and mortality of the population; and

WHEREAS, it is well within the scope of practice of ALL primary care physicians to treat this condition ~~**and obesity is not currently a payable diagnosis for primary care**~~; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) ~~publicly affirms and advocates that all diagnosis codes for obesity and morbid obesity be a billable and reimbursable diagnostic code for any and all practicing primary care physicians~~ IS COMMITTED TO EXPANDING PAYMENT FOR SERVICES RELATED TO OBESITY DIAGNOSIS AND TREATMENT, INCLUDING NON-PRIMARY CARE PHYSICIANS AND NON-PHYSICIANS WHO PROVIDE COUNSELING IN CONSULTATION WITH A PHYSICIAN; and, be it further

RESOLVED, that the AOA WILL work with ~~insurers,~~ payors, legislators, and other stakeholders to ensure access to treatment for obesity to address this public health epidemic.

References

1. Centers for Disease Control Overweight and Obesity, https://www.cdc.gov/obesity/data/adult.html; Accessed March 15, 2019.

Explanatory Statement: Submitted by Author:
None provided.

Explanatory Statement: Reference Committee
The Committee felt that the statement "obesity is not currently a payable diagnosis for primary care" may not always be the case and may vary from payor to payor. The change suggested would prevent the resolution from becoming obsolete and still convey the original intent.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: POST PARTUM DEPRESSION (Response to RES. NO. H-612 - A/18 referencing H-615-A/13)

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

WHEREAS, on July 21, 2018, the House of Delegates (HOD) Ad Hoc Reference Committee referred H615-A/13 POSTPARTUM DEPRESSION to the Bureau on Scientific Affairs and Public Health (BSAPH) to produce a report on outcomes; and

WHEREAS, at the 2019 HOD the BSAPH requested and received additional time to collect the requested data from AOA's internal sources as well external key stakeholders (e.g., COMS, osteopathic state, and specialty associates); and

WHEREAS, the BSAPH developed and administered a survey to its external stakeholders to collect the requested information and provide a final report to the HOD in 2020; now, therefore be it,

RESOLVED, that the Bureau of Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

H615-A/13 POSTPARTUM DEPRESSION

The American Osteopathic Association encourages its members to participate in continuing medical education programs on postpartum depression (PPD); urges colleges of osteopathic medicine (COMs) and osteopathic state and specialty associations to offer CME on PPD as part of their educational offerings; and endorses the use of screening tools and encourage the measurement of outcomes in their use. 2003; 2008; reaffirmed as amended 2013.

Explanatory Statement: Submitted by Author

Introduction

Postpartum depression is a type of depression that occurs after women give birth. Symptoms of postpartum depression are more severe and enduring than those of "baby blues," which describes the worry, sadness, and tiredness many women combat after having a baby. Postpartum depressive symptoms (PDS) are common, and they can impact the mother, infant and family. PDS have been linked to adverse maternal and infant outcomes, including low breastfeeding initiation and duration and poor maternal and infant bonding. (Ko JY, 2017)

Fathers may also experience depression during the first year of their child's life. According to the Centers for Disease Control and Prevention (CDC), about 1 out of 5 fathers will suffer one or more incidences of depression before their child reaches 12 years of age. Younger fathers, those with a history of depression, and those experiencing financial challenges were most susceptible. (Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, 2020)

Based on the Pregnancy Risk Assessment Monitoring System (PRAMS) data, the CDC estimates that 1 in 8 women nationally experience PDS. (America's Health Rankings, 2019). Estimates of the number of

women affected by postpartum depression vary by age and race/ethnicity. Additionally, postpartum depression estimates differ by state, and can be as high as 1 in 5 women (Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, 2020).

Postpartum depression may be prevented and/ or mitigated by ensuring women have supportive and psychological care following childbirth. This includes home visits, peer support and interpersonal therapy. (Donna E. Stewart, 2016) Additionally, Postpartum Depression (PPD) is treatable with social support, counseling, and/ or medication. Though most people recover with treatment of PPD, many are not screened or diagnosed (America's Health Rankings, 2019).

Studies indicate that 66 percent of past-year depression among pregnant women in the US were undiagnosed, and only half of pregnant women with depressive symptoms received treatment. Studies also uncovered several barriers to treatment among women with PPD, particularly among Latinx and African American women. Given the significant burden of PPD, and the fact that PPD is preventable and highly treatable, the US public health strategy, Healthy People 2020, includes an objective to reduce the number of women who experience postpartum depressive symptoms subsequent to a live birth. (America's Health Rankings, 2019)

Osteopathic CME Education on PPD

In 2020, the BSAPH distributed a survey to 150 osteopathic CME providers at colleges of osteopathic medicine (COMs) and osteopathic state and specialty associations to ascertain whether or not the affiliate groups offered continuing medical education programs on PPD, endorsed the use of screening tools, or encouraged outcomes measurement from 2014 through 2019.

Sixty-nine (46%) organizations responded to the survey. Nine respondents (13%) reported a total of 26 educational CME activities on PPD delivered to their constituents from 2014 through 2019. The majority of the activities were live events, and as many as 1200 learners participated. Three (4%) of the organizations also promoted screening tools and encouraged outcomes measurement.

Conclusions/ Recommendations

There has been some education in the osteopathic community on PPD. However, depression for many women across the country is still a very significant issue that is underdiagnosed and untreated. Therefore, it is recommended that the AOA continue to encourage the osteopathic community to provide and participate in continuing medical education on PPD and the best practices for screening, diagnosis, monitoring and treatment.

References

America's Health Rankings. (2019). *Health of Women and Children Report*. Retrieved April 28, 2020, from https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/postpartum_depression/state/ALL

Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. (2020, May 4). *Depression Among Women*. Retrieved from Centers for Diseas Control and Prevention, Reproductive Health: https://www.cdc.gov/reproductivehealth/depression/index.htm

Donna E. Stewart, C. M. (2016). Postpartum Depression. *N Engl J Med* , 2177-2186.

Ko JY, R. K. (2017). *Trends in Postpartum Depressive Symptoms — 27 States, 2004, 2008, and 2012. MMWR Morb Mortal Wkly Rep 2017*. doi:DOI: http://dx.doi.org/10.15585/mmwr.mm6606a1External.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: Up to approximately $130,000 in additional expense.
The amount of additional expense will depend upon the type of activity and number of CME hours involved. For example, a conservative estimate based upon a one CME hour journal article would be $13,000, whereas, a high-end estimate based upon a 10 credit CME in-person workshop could be $130,000.

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: REFERRED SUNSET RES. NO. H-619 - A/2019: H624-A/14 MANAGED CARE PLANS – SERVICE, ACCESS AND COSTS IN

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, the AOA House of Delegates referred sunset resolution H-619-A/2019 titled H624-A/14 MANAGED CARE PLANS – SERVICE, ACCESS AND COSTS IN to the Bureau of Socioeconomic Affairs for "clarification on intent of the resolution, definition of "open access models", and relevance of the resolution"; now, therefore be it

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED as AMENDED:

H624-A/14 MANAGED CARE PLANS – SERVICE, ACCESS AND COSTS IN

The American Osteopathic Association (AOA) supports efforts to ~~combine tiered formulary and open access models with~~ expand~~ed~~ THE use of variable co-pays ~~that reflect the total~~ THAT SUPPORT PROGRAM costs. ~~of these programs and~~ THE AOA ALSO supports efforts to design benefits that align consumer needs, ~~and~~ accountability and individual physician incentives. 1999; revised 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

Explanatory Statement: Submitted by Author:
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: RESEARCHING PATIENT SAFETY AND PROVIDER QUALIFICATIONS

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, mid-level practitioners, defined as, but not limited to, health-care providers such as nurse practitioners, nurse midwives, nurse anesthetists, clinical nurse specialists and physician assistants [1] have increasingly sought expanded scope of practice with success; and

WHEREAS, nurse practitioners (NPs) now have full scope of practice in 24 states with intention to continue expansion of scope efforts [2]; and

WHEREAS, NPs have introduced a new degree, DNP, or Doctor of Nursing Practice, that has increased confusion for patients in clinical settings, where said DNPs refer to themselves as doctors, and at times do not adequately inform patients that they are not physicians; and

WHEREAS, The Code of Federal Regulations defines the term physician to include doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law[7]; and

WHEREAS, The Social Security Administration defines physician to mean means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine, doctor of podiatric medicine, or doctor of optometry, or a chiropractor, legally authorized to practice by a State in which he/she performs this functions [within given parameters][8]; and

WHEREAS, Florida, New York, Arizona, Delaware have proposed laws limiting the use of doctor to persons with a Medical Doctor (MDs) or Doctor of Osteopathic Medicine (DOs) degree; Six states have passed laws making it a felony for nurse practitioners to refer to themselves as doctor; Nine states require nurse practitioners to follow their introduction with a clarifying statement [9,10,11]; and

WHEREAS, American Osteopathic Association (AOA) House of Delegates resolution number H324-A/14 states that the AOA opposes the misuse of the title "doctor" by non-physician clinicians, in all communications and clinical settings because such use deceived the public by implying that the non-physician clinician's education, training, or credentialing is equivalent to a DO or MD[13]; and

WHEREAS, attempts at promoting mid-level practitioners to independent practice is done without proper reverence to their important purpose in healthcare, as mid-level support for physicians; and

WHEREAS, such attempts are often aided by a gross oversimplification of the crucial role belonging to the primary care specialties to which NPs are often assumed to enter; and

WHEREAS, one major justification for the expanded numbers of these practitioners and their scopes of practice is the physician shortage, which is projected that by 2025, demand for physicians will exceed supply by a range of 46,000 to 90,000[3]; and

WHEREAS, we acknowledge that the physician shortage is a real and serious problem on the horizon, but we also cannot afford to sacrifice patient safety or care in the name of momentary expediency; and

WHEREAS, American physicians, Medical Doctors (MDs) or Doctor of Osteopathic Medicine (DOs), undergo one to two and a half additional years of schooling, three additional years of residency training, and fifteen to eighteen thousand more training hours than "Doctors of Nursing Practice"[4]; and

WHEREAS, physicians are trained to direct and lead care, while midlevel providers such as nurse practitioners are not, the DNP degree is administrative in nature and not an advanced clinical degree; and

WHEREAS, there is inadequate evidence to support a transition to midlevel independence; and

WHEREAS, we must applaud and support nurse practitioners stance that their educational model is "patient centered" and "holistic", we must interject that they are not unique in this view point and reject the accusation that the "medical model" is "disease focused"; and

WHEREAS, continually expanding midlevel provider scope of practice creates an opportunity for a two tiered healthcare system to develop, where rural and underserved populations have limited access to physician providers while those in larger cities have greater access to physician providers, further exacerbating existing disparities in healthcare; and

WHEREAS, the AOA has previously called for a review and validation of nonphysician credentials and standards of care and supported a position that patients should be made clearly aware at all times if they are being treated by a non-physician provider or clinician (H634-A/15)[6]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) ~~**supports**~~ **ENCOURAGES** independent research on the qualification and outcomes of nurse practitioners and other midlevel providers that practice independently**; AND, BE IT FURTHER**

RESOLVED, THAT THE AOA RESEARCH & PUBLIC HEALTH STAFF PERFORM AN ~~META~~ ANALYSIS OF CURRENT, VALID AND PUBLISHED RESEARCH ON CLINICAL OUTCOMES, RESOURCE UTILIZATION AND MALPRACTICE EXPERIENCE FOR INDEPENDENTLY PRACTICING NPS AND PAS AND PROVIDE THIS INFORMATION TO OSTEOPATHIC PHYSICIANS.

Explanatory Statement: Submitted by Author

Commonly it is asserted that midlevel providers provide access to rural communities. Firstly, the data shows that midlevel providers such NPs and PAs do not practice in rural areas in a statistically meaningfully different pattern as compared to physicians. Second, it is unjust to reinforce a two-tiered health care system by creating policy that promotes rural community care that is highly dependent on midlevel providers. Instead the policy focus should be to attract and retain physicians in rural areas. To solve a physician shortage, we must focus on physician policy.

References

1. Catherine S. Bishop, Dnp, Np, Aocnp®. (2012). Advanced Practitioners Are Not Mid-Level Providers. Journal of the Advanced Practitioner in Oncology, 3(5). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4093350/
2. Carlson, K. (2017, March 2). NP Practice Authority Grows - March 2017 Update. Retrieved February 22, 2020, from https://nurse.org/articles/nurse-practitioner-scope-of-practice-expands-mar17/
3. AAMC. (2015, March 1). Physician Supply and Demand Through 2025: Key Findings. Retrieved February 22, 2020, from https://www.aamc.org/download/426260/data/physiciansupplyanddemandthrough2025keyfindings.pdf
4. Primary Care Coalition. (n.d.). Compare the Education Gaps Between Primary Care Physicians and Nurse Practitioners. Retrieved from https://www.tafp.org/Media/Default/Downloads/advocacy/scope-education.pdf
5. H634-A/15, AOA HOD Cong. (2015) (enacted)
6. 20 CFR 702.404 - Physician defined. (n.d.). Retrieved February 25, 2020, from https://www.law.cornell.edu/cfr/text/20/702.404
7. SSA - POMS: HI 00401.295 - Physician Defined. (2015, April 06). Retrieved February 25, 2020, from https://secure.ssa.gov/poms.nsf/lnx/0600401295
8. DECAPUA, D. (2016, April 28). Are Nurse Practitioner Doctors Real Doctors? Retrieved February 24, 2020, from https://www.bartonassociates.com/blog/are-nurse-practitioner-doctors-real-doctors/
9. Harris, G. (2011, October 01). When the Nurse Wants to Be Called 'Doctor'. Retrieved February 24, 2020, from http://www.nytimes.com/2011/10/02/health/policy/02docs.html
10. State medical boards trying to limit who can be called "Doctor". (n.d.). Retrieved February 24, 2020, from https://www.clinicaladvisor.com/the-waiting-room/state-medical-boards-trying-to-limit-who-can-be-called-doctor/article/284167/
11. D-35.992, AMA BOT Cong. (2016) (enacted)
12. H324-A/14, AOA HOD Cong. (2014) (enacted)

Background Information: Provided by AOA Staff

Current AOA Policy: H613-A/16 PHYSICIAN SUPPLY IN RURAL, UNDERSERVED UNITED STATES – RECOMMENDATIONS FOR IMPROVING

Prior HOD action on similar or same topic: Policy reaffirmed in 2016.

FISCAL IMPACT: $102,500 in additional expenses over a two (2) year period.

The additional expense would be incurred if AOA sponsors the research. Additional expenses would include: Initiate/Manage Grant Award $1,500; Grant Reviewers $1,000; grant award of $100,000.

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: SUPPORT THE BOLSTERING OF VETERAN HEALTH ADMINISTRATION RESOURCES THROUGH PROVIDER PAY REFORM

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, veterans represented 7% (approximately 22.6 million people) of the United States population in 2016[1]; and

WHEREAS, the Veterans Administration (VA) pays private contractors up to $295-300 for each authorization of private care per veteran[2]; and

WHEREAS, existing health services provided directly by the United States Department of Veterans Affairs remain hindered by chronic staffing shortages including 138 of 140 facilities reporting shortages of physicians, especially primary care and psychiatry specialties, and 108 of 140 facilities reporting shortages of nursing occupations[3]; and

WHEREAS, existing health services provided directly by the United States Department of Veterans Affairs remain hindered by uncompetitive pay because of outdated Office of Personnel Management (OPM) classifications preventing the ability to offer more competitive salaries or advancement opportunities[4]; and

WHEREAS, existing health services provided directly by the United States Department of Veterans Affairs remain hindered by personnel management issues including a lack of data on contract physicians and physician trainees resulting in insufficient workforce planning [5]; and

WHEREAS, VA physicians are more knowledgeable about the care for combat injuries, post-traumatic stress disorder, and other health injuries the veteran population faces[6]; and

WHEREAS, American Osteopathic Association (AOA) Resolution H-614-A/18 reaffirms the support of adequate healthcare funding and use of community physicians "when Veterans' Health Administration facilities cannot provide adequate or timely access"[7]; now, therefore be it

RESOLVED, that the American Osteopathic Association support both staffing management and competitive pay reform at the Veterans' Health Administration (VHA) to ensure that a full, stable workforces, as budgeted by the Department of Veterans Affairs, is available to meet the health needs of the United States veteran population.

Explanatory Statement: Submitted by Author

Per Resolution H617-A/13, SOMA and the AOA already supports adequate federal funding for health care for veterans at all VHA facilities, as well as federal funding for services from community health providers when VHA facilities are unable to provide adequate or timely access. SOMA and the AOA should advocate for improvements to existing VHA health care services by overhauling staffing data and management; thus, better allowing the VHA to strengthen its current services and provider pool by offering more competitive pay. These issues have been ongoing for years. Not enough has been done to ensure the VHA, which provides care to millions of Americans, keeps a level of modernity adequate enough to meet estimated needs. Addressing these issues would help reduce the need to rely on private health services, which have not met expectations for timeliness.

The intention of this resolution is to provide broad language for SOMA and the AOA to tackle these positions in a manner they find appropriate, without limiting methodology.

References

1. Bialik, K. (2017, November 10). 5 facts about U.S. veterans. Retrieved from https://www.pewresearch.org/fact-tank/2017/11/10/the-changing-face-of-americas-veteran-population/
2. VA Office of Inspector General. (2017, January 17). Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System. https://www.va.gov/oig/pubs/VAOIG-15-03036-47.pdf
3. Veteran Health Administration. (2018, June 21). Steps Taken to Improve Physician Staffing, Recruitment, and Retention, but Challenges Remain. Retrieved from https://www.gao.gov/assets/700/692661.pdf
4. Daigh, J. D. (2018, June 14). OIG Determination of Veterans Health Administration's Occupational Staffing Shortages: FY 2018. Retrieved from https://www.va.gov/oig/pubs/VAOIG-18-01693-196.pdf
5. Draper, D. A. (2018, June 21). Steps Taken Lab to Improve Physician Staffing, Recruitment, and Retention, but Challenges Remain. Retrieved from https://docs.house.gov/meetings/VR/VR03/20180621/108430/HHRG-115-VR03-Wstate-DraperD-20180621.pdf
6. Tanielian, T., Farmer, C.M., Burns, R.M., Duffy, E.L., Setodji, C.M. (2018). Ready or not? Assessing the Capacity of New York State Health Care Providers to Meet the Needs of Veterans. https://www.rand.org/pubs/research_reports/RR2298.html
7. American Osteopathic Association 98th Annual House of Delegates Meeting. (2018). *https://osteopathic.org/wp-content/uploads/2018-HOD-Resolutions-with-action.pdf*

Background Information: Provided by AOA Staff

Current AOA Policy: H414-A/18 ENVIRONMENTAL HEALTH

Prior HOD action on similar or same topic: Policy reaffirmed in 2018.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED**

DATE: **October 13, 2020**

SUBJECT: TELEMEDICINE; REIMBURSEMENT FOR

SUBMITTED BY: New York State Osteopathic Medical Society

REFERRED TO: Ad Hoc Committee

WHEREAS, the world continues to face a global health crisis through the pandemic spread of the corona virus COVID-SARS-19; and

WHEREAS, the health and safety of the peoples throughout the United States is uncertain; and

WHEREAS, in 2018 the Directorate for Global Health Security and Biodefense was shut down thereby limiting the national ability to respond to an emerging infectious disease crisis; and

WHEREAS, school districts throughout the United States have cancelled classes and look to digital platforms for instruction and have revisited and redefined the need for face-to-face time in the classroom, including hybrid versions of in-person and virtual encounters; and

WHEREAS, the number of confirmed cases and deaths in the United States continues to rise; and

WHEREAS, the disease continues to pose a heightened risk to those with immunocompromised and other vulnerable populations including the elderly, those with chronic lung disease, heart disease, cancer, and/or diabetes; and,

WHEREAS, a number of states witnessed their governor declaring public health states of emergency; and

WHEREAS, there has been inconsistent responses in such states as to quarantining measures, prevention techniques including masking and social distancing, and

WHEREAS, currently there are a number of United States' residents under mandatory quarantine and a far greater number confined to voluntary home isolation; and

WHEREAS, emergency responders have adopted policies that are designed to limit potential spread of the virus and some departments have been directed not to respond to calls from individuals that are experiencing coughs with high fevers and to also cease efforts of life-support or avoid transportation to hospitals for more definitive care if stricken citizens are above a certain age and/or if there was an extended effort; and

WHEREAS, individuals are instructed NOT to go to their physicians' offices if experiencing cough with fever unless they are in a high risk situation or experiencing shortness of breath when they are told to present to the emergency department of a hospital; and

WHEREAS, individuals ill with other medical conditions may likewise avoid needed in-person medical evaluation and treatment for fear of infection exposure; and

WHEREAS, on March 4, 2020, Congress voted to approve an emergency COVID-SARS-19 spending bill of 8.3 billion dollars to address this growing health crisis; and

WHEREAS, the medical community and community health centers serve as vital role in the maintenance of health and prevention of disease; and

WHEREAS, after 9/11/2001, the country watched as St. Vincent Hospital and Medical Center of New York City took on the role of receiving hospital for 9/11 workers and sustained incredible financial losses from which the hospital did not recover and was forced to close, and identified the particular risk to those who selflessly put themselves and their institution in harm's way for the good of the peoples in their community; and

WHEREAS, the physicians and other medical providers in the private sector must be enabled to respond to the growing need for medical services including mandatory quarantine and voluntary isolation; and

WHEREAS, technology is available to patients and physicians alike to allow for personalized advice and management through various means including telephonic and video communications (telemedicine); and

WHEREAS, there is acceptance of the utilization telemedicine for geographic areas where access to physicians and other health care providers is not readily accessible; and

WHEREAS, there are means available for these situations and circumstances for these physicians and others to be paid for their services using such telemedicine technology that was enacted on a temporary emergency basis; and

WHEREAS, the COVID-19 pandemic has created situations where persons are instructed to limit personal access to their physicians in an effort to curtail the spread of the contagion; and

WHEREAS, it is essential to provide up-to-the-minute information and medical care as safely and efficiently as possible, and

WHEREAS, the guidelines that determine that combined audio-visual interaction is necessary for one level of payment versus strictly telephonic interaction at another fails to recognize that those who are of a certain age or economic status may not have the means to utilize other than verbal-auditory interaction; and

WHEREAS, Medicare's coverage of telemedicine is slated to end in the near future if no extension is enacted and especially when the coronavirus no longer poses a public health emergency, and

WHEREAS, private insurers, which followed the federal government's lead, could revert to paying doctors for virtual visits at a fraction of the cost for traditional visits, if anything at all; now, therefore be it

RESOLVED, that the American Osteopathic Association work with the American Medical Association to advocate for legislation or an Executive Order to mandate that all health insurance plans, including those issued by CMS (Medicaid and Medicare Services) and entities covered under ERISA Law continue to reimburse for such services at a level that is commensurate with a ~~**level 4**~~ face-to-face visit~~**; and be it further**~~

~~**RESOLVED that community health centers, physicians and other clinical practitioners be directed to submit claims for services to individuals who have no health insurance to their respective State Offices of Emergency Management so as to utilize emergency funds approved by Congress so as to be able to provide medical care to the widest population of at-risk individuals as possible.**~~

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy:
H613-A/16 PHYSICIAN SUPPLY IN RURAL, UNDERSERVED UNITED STATES – RECOMMENDATIONS FOR IMPROVING

H601-A/17 TELEMEDICINE – AOA POLICY ON

H343-A/18 PHYSICIAN PAYMENT FOR ELECTRONIC ADVICE, COUNSELING AND TREATMENT PLANS

H630-A/19 COMMUNICATION TECHNOLOGY-BASED AND REMOTE EVALUATION SERVICES

Prior HOD action on similar or same topic: H613-A/16 policy reaffirmed as amended in 2016; H601-A/17 policy reaffirmed as amended in 2017; H348-A/18 policy reaffirmed in 2018; H630-A/19 policy approved in 2019.

FISCAL IMPACT: $0

ACTION TAKEN: **ADOPTED as AMENDED**

DATE: **October 13, 2020**

SUBJECT: **A PROCLAMATION** REGARDING THE INACCURATE PORTRAYALS OF US TRAINED DOs IN MEDIA

SUBMITTED BY: Florida Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, 120,000 osteopathic physicians are currently working in the US Healthcare system, and

WHEREAS, more than half of the current DOs practice in primary care specialties, and

WHEREAS, DOs have served in many levels of healthcare including state Surgeon Generals, the Surgeon General of the Army, Physician to Vice President Biden, and Physician to President Donald Trump, among others, and

WHEREAS, U.S. trained DOs have practice parity with Allopathic Physicians in all 50 states, and in many foreign nations, and

WHEREAS, on October 5, 2020 Rachel Maddow, during her show televised on MSNBC, referred to a DO as an Osteopath and implied he was not qualified to render medical care, and

WHEREAS, other journalists have made similar comments in print and on social media, and

WHEREAS, the demeaning effects of these comments represent an ongoing detriment to the perception of the thousands of Osteopathic Physicians among the people and the communities they serve, and

WHEREAS, the American Osteopathic Association has advocated and educated news agencies and the general public through formal campaigns and social media, and

WHEREAS, these efforts have resulted in appropriate news articles in the Atlantic, the LA Times and other publications, and

WHEREAS, these efforts have resulted in over one half million engagements on social media within the first 72 hours of this issue developing, now therefore, be it

PROCLAIMED by the American Osteopathic Association House of Delegates on this day, November 7, 2020, that we are

RESOLVED that the leadership and members of the American Osteopathic Association (AOA) condemn the poorly researched and patently incorrect statements regarding the ~~limits~~ **SCOPE OF PRACTICE** of U.S. trained DOs made by journalists; and, be it further

PROCLAIMED, that the American Osteopathic Association will continue ongoing efforts using social media and other means to educate the public and dispel inaccuracies of U.S. trained DOs; and, be it further

PROCLAIMED, that the American Osteopathic Association encourages its members, affiliated organizations, our patients and our Allopathic colleagues to use social media and other means to accurately represent the profession of Osteopathic Medicine to the public; and, be it further

PROCLAIMED, that the American Osteopathic Association will continue to provide online resources and support to its members and advocates to develop a grassroots social media campaign to further the understanding of the profession of Osteopathic Medicine by the public; **AND, BE IT FURTHER**

PROCLAIMED, THAT THE AMERICAN OSTEOPATHIC ASSOCIATION ON BEHALF OF THE OSTEOPATHIC PROFESSION EXPRESSES APPRECIATION AND GRATITUDE TO THE JOURNALISTS, ORGANIZATIONS, AND OTHER PERSONS THAT SUPPORT AN ACCURATE PORTRAYAL OF OSTEOPATHIC MEDICINE AND OSTEOPATHIC PHYSICIANS IN THE MEDIA.

Explanatory Statement: Submitted by Author
None provided.

FISCAL IMPACT:

ACTION TAKEN **ADOPTED**

DATE **November 7, 2020**