AMERICAN OSTEOPATHIC ASSOCIATION

2025 House of Delegates Resolutions

Actions

July 2025

AMERICAN OSTEOPATHIC ASSOCIATION

200 Series
Educational Affairs
Resolutions

Actions

142 E. Ontario St.
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105th ANNUAL AOA HOUSE OF DELEGATES MEETING
2025 RESOLUTION ROSTER (200 SERIES)
As of 07-19-25

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	Reference Committee	Action
H-200	Rural Sites – Osteopathic Education in (SR-Source-H201-A/20)	BOE	Educational Affairs	Adopted
H-201	Graduate Medical Education – Training of U.S. Medical School Graduates (SR-Source-H200-A/20)	BOE	Educational Affairs	Adopted
H-202	Directors of Medical Education Overseeing Osteopathic Postdoctoral Training Programs (SR-Source-H202-A/20)	BOE	Educational Affairs	Adopted
H-203	Blue Ribbon Commission (SR-Source-H205-A/20)	BOE	Educational Affairs	Sunset
H-204	Autopsies (SR-Source-H203-A/20)	BOE	Educational Affairs	Adopted
H-205	Incorporating Continued Medical Education Regarding Intellectual and Developmental Disabilities (SR-Source-H209-A/20)	BOE	Educational Affairs	Adopted as Amended
H-206	Audition Rotations for Osteopathic Medical Students (SR-Source-H214-A/20)	BOE	Educational Affairs	Adopted as Amended
H-207	Classification of Osteopathic Medical Graduates as U.S. Medical Graduates in Eras (SR-Source-H230-A/19; Referred-H210-A/24)	BOE	Educational Affairs	Adopted as Amended
H-208	Interdisciplinary Education and High Value Care (Source-Referred-H216-A/24)	BOE	Educational Affairs	Adopted as Amended
H-209	Osteopathic Medical School Education (Source-Referred-H224-A/24)	BOE	Educational Affairs	Adopted as Amended
H-210	Osteopathic Primary Care in Small Communities	POMA (Pennsylvania)		Withdrawn
H-211	Addressing COMLEX-USA Discrimination in Family Medicine Residency Programs and Promote Transparency for Osteopathic Medical Students	ACOFP	Educational Affairs	Adopted as Amended
H-212	Inclusion of Osteopathic Manipulative Treatment OMT) Procedures in ACGME Case Logs	OOA (Ohio)	Educational Affairs	Adopted as Amended
H-213	Support of Osteopathic Recognition and the Integrity of Osteopathic Training	OOA (Ohio)	Educational Affairs	Referred to OOA

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Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-214	Osteopathic Medical Student Audition Rotations	OPSC (California)	Educational Affairs	Adopted as Amended
H-215	GME Equity Annual Report (Source-H345-A/23)	BOE	Educational Affairs	Adopted

SUBJECT: RURAL SITES – OSTEOPATHIC EDUCATION IN - SOURCE: H201-A/20

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

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

6 The American Osteopathic Association (AOA) encourages clinical rotations in rural
7 settings by osteopathic medical students and graduates during their respective
8 predoctoral and postdoctoral education programs.

Background Information: Provided by AOA Staff
Current AOA Policy: 1990; 1995 Reaffirmed as Amended; 2000 Reaffirmed; 2005 Reaffirmed; 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic:
H216-A/21 Rural Healthcare Provided by Current AOA GME Programs - Preservation of
H439-A/21 Physician Supply in Rural, Underserved United States – Recommendations for Improving

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: GRADUATE MEDICAL EDUCATION – TRAINING OF US MEDICAL SCHOOL GRADUATES - SOURCE: H200-A/20

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

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

6 The American Osteopathic Association (AOA) advocates for the elimination of
7 limitations on the number of funded graduate medical education positions to
8 accommodate increases in US medical school enrollment; places great emphasis
9 on establishing graduate medical education opportunities for osteopathic medical
10 school graduates in geographic areas that lack adequate training capacity and as
11 needed to meet future workforce needs.

Background Information: Provided by AOA Staff
Current AOA Policy: 2009; 2014 Referred; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic:
H-202-A/24 Graduate Medical Education – Increasing Opportunities
H-327-A/24 State Graduate Medical Education Funding Alternatives
H218-A/21 Graduate Medical Education Funding and Incentives

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: DIRECTORS OF MEDICAL EDUCATION OVERSEEING OSTEOPATHIC POSTDOCTORAL TRAINING PROGRAMS - SOURCE: H202-A/20

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

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

6 The American Osteopathic Association (AOA) will encourage the continued
7 teaching of osteopathic principles and practices through but not limited to
8 osteopathic recognition in graduate medical education programs and encourages
9 osteopathic physicians to seek faculty and administrative positions in graduate
10 medical education programs.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010, 2015 Reaffirmed; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic:
H214-A/22 Osteopathically Recognized Graduate Medical Education Programs
H-618- A/23 Osteopathic Graduate Medical Education

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: BLUE RIBBON COMMISSION REPORT - SOURCE: H205-A/20

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy; and

3 WHEREAS, only college of osteopathic medicine (COM) has pursued an innovative
4 pilot program, but it does not follow all of the recommendations in the Blue
5 Ribbon Commission; and

6 WHEREAS, the Bureau of Osteopathic Education has contacted the leadership of
7 the COM and confirmed the first cohort is now board certified; and

8 WHEREAS, the Bureau of Osteopathic Education believes the monitoring of pilot
9 programs "to produce primary care, competency-based physician team
10 leaders" is the responsibility of the AOA Commission on Osteopathic College
11 Accreditation (COCA); and

12 WHEREAS, the Bureau of Osteopathic Education, with support from this COM's
13 leadership, determined this resolution is no longer applicable; now, therefore
14 be it

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

17 The American Osteopathic Association (AOA) encourages colleges of osteopathic
18 medicine to collaborate with appropriate regulatory authorities, licensing boards,
19 certifying boards, the National Board of Osteopathic Medical Examiners, and other
20 stakeholders in their pursuit of innovative pilot studies to produce primary care,
21 competency-based physician team leaders and the AOA will monitor the outcomes
22 of these pilot programs and the route to board certification.

23 To inform their recommendation, the BOE first asked AOA to reach out to any pilot
24 programs currently in existence to provide information. One COM has a pilot
25 program and one cohort has completed medical school and family medicine
26 residency and they are all now AOBFP and/or ABFM certified. Since this
27 resolution's approval, only one school has pursued an innovative pilot program. The
28 BOE sought input from this COM's leadership on this resolution and they support
29 sunset. The monitoring of pilot programs "to produce primary care, competency-
30 based physician team leaders" is the responsibility of the AOA Commission on
31 Osteopathic College Accreditation (COCA).

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Sunset_________

DATE: ____July 19, 2025____________

SUBJECT: AUTOPSIES - SOURCE: H203-A/20

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

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

6 The American Osteopathic Association (AOA) encourages medical schools, private
7 hospital systems and public medical facilities to allow the viewing of autopsies by
8 medical students and residents for teaching purposes.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted__________

DATE: ____July 19, 2025____________

SUBJECT: INCORPORATING CONTINUED MEDICAL EDUCATION REGARDING INTELLECTUAL AND DEVELOPMENTAL DISABILITIES - SOURCE: H209-A/20

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Education has reviewed the policy and determined that it remains relevant; now, therefore be it

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

The American Osteopathic Association (AOA) encourages continuing medical education opportunities regarding intellectual and developmental disability care ~~for adults~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2020 Adopted as Amended

Prior HOD action on similar or same topic: As noted above

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: AUDITION ROTATIONS FOR OSTEOPATHIC MEDICAL STUDENTS - SOURCE: H214-A/20

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Education has reviewed the policy and determined that it remains relevant; now, therefore be it

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

The American Osteopathic Association (AOA), partner with interested stakeholders including, but not limited to, the **A**~~a~~ssociation of American Medical Colleges (AAMC) and American Association Of Colleges Of Osteopathic Medicine (AACOM) to address the discriminatory practice of prohibiting medical students from visiting student rotations or charging different fees to medical students based solely on their osteopathic training; and, that the AOA work with any and all relevant organizations to seek necessary changes in institutional or residency policies and/or practices that prohibit visiting student rotations or charge inequitable fees to ~~medical students based solely on their osteopathic training against~~ osteopathic medical students or **OSTEOPATHIC** residents; and, that the AOA will continue to advocate for osteopathic medical students and **OSTEOPATHIC** residents with institutions, programs, and other relevant stakeholders when the AOA becomes aware of any instance of discrimination.

Background Information: Provided by AOA Staff
Current AOA Policy: 2020 Adopted as Amended

Prior HOD action on similar or same topic: As noted above.

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: CLASSIFICATION OF OSTEOPATHIC MEDICAL GRADUATES AS US MEDICAL GRADUATES IN ~~ERAS~~ **RESIDENCY/FELLOWSHIP APPLICATION SERVICES** – Source: H230-A/19

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, the Bureau of Osteopathic Education (BOE) submitted H-210 A/24 Classification of Osteopathic Medical Graduates as U.S. Medical Graduates in ERAS (Source H-230 A/19) to the 2024 House of Delegates and recommended that it be sunset; and

WHEREAS, the 2024 House of Delegates referred this policy back to BOE to update the policy to include other residency application services; and

WHEREAS, the BOE has reviewed the policy and revised it to be inclusive of additional residency application services; now, therefore be it

RESOLVED, that the BOE recommends that the following policy be REAFFIRMED AS AMENDED.

Classification of Osteopathic Medical Graduates as U.S. **OSTEOPATHIC** Medical Graduates in ~~ERAS~~ **RESIDENCY/FELLOWSHIP APPLICATION SERVICES** (Source H-230 A/19)

The American Osteopathic Association advocates to ~~the American Association of Medical Colleges to adjust Electronic~~ **ALL** Residency/**FELLOWSHIP** Application Services **ADJUST** filters based on medical school type such that Osteopathic applicants are included and recognized within the U.S. **DO/OSTEOPATHIC** ~~Public or Private~~ Medical Graduates categor~~y~~**IES**.

Explanatory Statement: Following the adoption of this resolution in 2019, AOA staff met with Electronic Residency Application Service (ERAS) staff to advocate for a change to the medical school type listing in ERAS.

2019 ERAS medical school type	2020-present ERAS medical school type
Canadian	Canadian School
International	International School
Osteopathic	US D.O. School
US Private School	US M.D. Private School
US Public School	US M.D. Public School

The BOE supports the current listing in ERAS and believes that osteopathic medical schools should be distinctly listed and recommends the policy language be broadened to all residency application services.

Background Information: Provided by AOA Staff
Current AOA Policy: 2019; 2024 Referred

Prior HOD action on similar or same topic:
H210-A/24 Referred to Bureau of Education

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025________________

SUBJECT: ~~INTERDISCIPLINARY~~ **MULTISPECIALTY** EDUCATION AND HIGH VALUE CARE
- SOURCE-REFERRED-H216-A/24

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, the Montana Osteopathic Medical Association submitted resolution H-216 A/24 Interdisciplinary Education and High Value Care to the 2024 House of Delegates; and

WHEREAS, the 2024 House of Delegates referred this resolution to the Bureau of Education (BOE) to clarify the intent of the resolution; and

WHEREAS, the BOE has reviewed the resolution and discussed with the author the intent of the proposed resolution; now, therefore be it

RESOLVED, that the BOE recommends that the following resolution be APPROVED as Policy.

~~Interdisciplinary~~ **MULTISPECIALTY OSTEOPATHIC** Education and High Value Care

The American Osteopathic Association (AOA) ~~explore and define ways to~~ encourages interdisciplinary ~~(~~**MULTI**specialty~~)~~ education and collaboration to further promote high-value care in all levels of education: ~~Colleges of Osteopathic Medicine (COM's)~~ **UNDERGRADUATE MEDICAL EDUCATION (UME),** graduate medical education (GME) ~~through communication with the Accreditation Council of Graduate Medical Education (ACGME),~~ and continuing medical education (CME).

The AOA will work with osteopathic stakeholders to promote this educational focus, including: the American Association of Colleges of Osteopathic Medicine (AACOM), the National Board of Osteopathic Medical Examiners (NBOME), **THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDCUATION (ACGME), COLLEGES OF OSTEOPATHIC MEDICINE**, ~~and~~ osteopathic specialty colleges, **OSTEOPATHIC** ~~STATE~~ **DIVISIONAL SOCIETIES AND AOA-ACCREDITED CME SPONSORS**.

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

Prior HOD action on similar or same topic:
H216/A24-Referred to Bureau of Education

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025________________

SUBJECT: OSTEOPATHIC MEDICAL SCHOOL EDUCATION
-SOURCE: REFERRED H224-A/24

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Educational Affairs

WHEREAS, the Maryland Association of Osteopathic Physicians submitted resolution H-224 A/24 Osteopathic Medical School Education to the 2024 House of Delegates; and

WHEREAS, the 2024 House of Delegates referred this resolution to the Bureau of Education (BOE) to review the proposed resolution following the release of the AACOM/ACGME/AAMC shared Foundational Core Competencies for Undergraduate Medical Education; and

WHEREAS, the BOE has reviewed the resolution and shared competency document; now, therefore be it

RESOLVED, that the BOE recommends that the following resolution be APPROVED as policy.

Osteopathic Medical School Education

~~RESOLVED, that the American Osteopathic Association work to define the specific competencies taught to DO students that differentiate DO education, and;~~

~~RESOLVED, that the AOA engage subject matter experts engaged in osteopathic medical education to delineate the details of the difference in educational experiences to include pathways for MD's to acquire the skills mastered by DO students.~~

THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) RECOGNIZES THAT IT IS IN THE BEST INTEREST OF OSTEOPATHIC MEDICINE TO INCORPORATE OSTEOPATHIC PRINCIPLES AND PRACTICE (OPP) INTO ALL THE SHARED FOUNDATIONAL CORE COMPETENCIES FOR UNDERGRADUATE MEDICAL EDUCATION SINCE OPP IS THE ESSENTIAL FOUNDATION TO EACH AND EVERY ASPECT OF THE EVALUATION, DIAGNOSIS AND CARE OF OUR PATIENTS. THE AOA STRONGLY SUPPORTS AND ENCOURAGES THE INTEGRATION OF OPP INTO ALL OF THE SHARED FOUNDATIONAL CORE COMPETENCIES FOR UNDERGRADUATE MEDICAL EDUCATION IN COLLEGES OF OSTEOPATHIC MEDICINE (COMS).

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

Prior HOD action on similar or same topic:
H224-A/24-Referred to Bureau of Education

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ________July 19, 2025____________

SUBJECT: ~~ADDRESSING COMLEX-USA DISCRIMINATION IN FAMILY MEDICINE RESIDENCY PROGRAMS AND PROMOTE~~ **PROMOTING** TRANSPARENCY FOR OSTEOPATHIC MEDICAL STUDENTS

SUBMITTED BY: American College of Osteopathic Family Physicians (ACOFP)

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, osteopathic medicine is one of the fastest growing segments of healthcare in
2 the United States, representing more than 11% of US physicians, and Colleges of
3 Osteopathic Medicine currently educate more than 35,000 physicians, 25% of all
4 U.S. medical students [1]; and

5 WHEREAS, the Comprehensive Osteopathic Medical Licensing Examination of the United
6 States (COMLEX-USA) is the licensing exam series required by the Commission
7 on Osteopathic College Accreditation (COCA) to be taken by all osteopathic (DO)
8 medical students in order to graduate from COCA-accredited medical schools [2];
9 and

10 WHEREAS, the United States Medical Licensing Examination (USMLE) is the licensing
11 exam series taken by all allopathic (MD) medical students [3]; and

12 WHEREAS, the COMLEX-USA and USMLE are ~~equivalent medical licensing exams~~
13 **BOTH VALIDATED LICENSING EXAMS FOR THEIR RESPECTIVE**
14 **EXAMINEES**, ~~supported by published predictive validity and score concordance~~
15 ~~studies [4];~~ and

16 WHEREAS, despite, from 2015 to 2020, residency training consolidation under a single
17 accreditor, the Accreditation Council for Graduate Medical Education (ACGME) for
18 all US residency and fellowship programs, many US residency programs do not
19 report both minimum COMLEX-USA and USMLE scores [5, 6]; and

20 ~~WHEREAS, many prospective osteopathic family medicine students wish to do their best~~
21 ~~to get into their preferred programs; and~~

22 ~~WHEREAS, there are current efforts, such as The Fair Access in Residency (FAIR) Act~~
23 ~~introduced to the 118th Congress in 2023-2024 [7]; and~~

24 ~~WHEREAS, 63.79% of graduated DO students in 2022 and 60.80% of graduated DO~~
25 ~~students took USMLE 1 [8-10]; and~~

26 ~~WHEREAS, 71.19% of graduated DO students in 2020 and 59.71% of graduated DO~~
27 ~~students took USMLE 2 [8-10]; and~~

28 WHEREAS, most osteopathic students take the USMLE to gain ~~advantage~~ **PERCEIVED**
29 **PARTIY** in residency selection, but at a financial and mental strain [11-12]; and

30 WHEREAS, osteopathic students ~~are~~ **MAY BE** unaware of measures to advocate for
31 themselves and their osteopathic distinctiveness and the COMLEX-USA [13]; ~~and~~
32 **NOW THEREFORE BE IT**

33 ~~WHEREAS, family medicine residency programs can help alleviate these strains and~~
34 ~~provide more transparency for qualified and interested osteopathic family~~
35 ~~physicians in their journeys to residency; now, therefore be it~~

36 RESOLVED, that the American Osteopathic Association (AOA) **CONTINUES** to advocate
37 for residency programs to provide yearly statistics ~~on~~ **TO PROSPECTIVE** ~~their~~
38 ~~incoming~~ **RESIDENCY APPLICANTS.** ~~residency classes, examples including but~~
39 ~~not limited to, the mean Comprehensive Osteopathic Medical Licensing~~
40 ~~Examination of the United States (COMLEX-USA) score of accepted students, the~~
41 ~~percentage of DO students accepted, and the percentage of accepted DO~~
42 ~~residents that took United States Medical Licensing Examinations (USMLE); and,~~
43 ~~be it further~~

44 ~~RESOLVED, that the AOA encourages osteopathic medical students and graduates to~~
45 ~~report any instances of COMLEX-USA discrimination from family medicine~~
46 ~~residency programs to the AOA and to the National Board of Osteopathic Medical~~
47 ~~Examiners (NBOME) to assist in increasing the number of DO medical trainees~~
48 ~~accepted into their desired family medicine residency programs.~~

References:

1. American Osteopathic Association. (2022). Osteopathic Medical Profession Report. https://osteopathic.org/index.php?aam-media=/wp-content/uploads/2022-AOA-OMP-Report.pdf
2. NBOME. (n.d.). COMLEX-USA. Retrieved May 5, 2023, from https://www.nbome.org/assessments/comlex-usa/
3. LCME. (2015). *Scope and Purpose of Accreditation*. Retrieved May 5, 2023, from https://lcme.org/about/. Published December 30, 2015
4. Barnum, S., & Craig, B., Wang, X., et al. (2022). A Concordance Study of COMLEX-USA and USMLE Scores. Journal of Graduate Medical Education. https://pubmed.ncbi.nlm.nih.gov/35222821/
5. ACGME. (2015). History of the Transition to a Single GME Accreditation System. Retrieved January 13, 2025, from https://www.acgme.org/about/transition-to-a-single-gme-accreditation-system-history/#:~:text=The%20transition%20to%20a%20single%20US%20graduate%20medical%20education%20(GME,of%20Osteopathic%20Medicine%20(AACOM)%E2%80%94
6. Nikolla, D., Mudrakola, V., Feronti, C., Bilski, S., & Bowers, K. (2023). Minimum United States Medical Licensing Examination and Comprehensive Osteopathic Medical Licensing Examination Scores Often Do Not Align. Cureus. https://pmc.ncbi.nlm.nih.gov/articles/PMC10576438/
7. H.R.751 - FAIR Act, 118th Congress (2023). https://www.congress.gov/bill/118th-congress/house-bill/751/text
8. Performance Data. (2022). https://www.usmle.org/performance-data

9. Performance Data. (2020). https://www.usmle.org/performance-data
10. Osteopathic Students Make up Growing Percent of Medical School Graduates. (2024). American Association of Colleges of Osteopathic Medicine. https://www.aacom.org/news-reports/news/2024/04/08/osteopathic-students-make-up-growing-percent-of-medical-school-graduates#:~:text=Today%2C%20more%20than%2035%2C000%20future,teaching%20locations%20in%2035%20states.
11. Ahmed, H., & Carmody, J. (2022). COMLEX-USA and USMLE for Osteopathic Medical Students: Should We Duplicate, Divide, or Unify? Journal of Graduate Medical Education. https://pmc.ncbi.nlm.nih.gov/articles/PMC8848882/
12. Tackett, S., Jeyaraju, M., Moore, J., Hudder, A., Yingling, S., Park, Y. S., & Grichanik, M. (2022). Student well-being during dedicated preparation for USMLE Step 1 and COMLEX Level 1 exams. BMC Medical Education. https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-021-03055-2
13. NBOME. (n.d.). Education & Advocacy. Retrieved January 13, 2025, from https://www.nbome.org/what-we-do/education-advocacy/

Background Information: Provided by AOA Staff
Current AOA Policy:
H345-A/23 AOA Support for GME Equity
H348-A/24 GME Equity Annual Report 2024

Prior HOD action on similar or same topic:
H231-A/19 Recognition of COMLEX and USMLE as Equal Licensing Examinations Among Residency Programs - adopted as amended (does NOT address the requirement for ACGME residency programs to share data as requested in this specific resolution; DOES address collaboration with NBOME, AACOM, etc., to educate ACGME Residency Program Directors regarding COMLEX/USMLE parity)

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: INCLUSION OF OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) PROCEDURES IN ACGME CASE LOGS

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Educational Affairs

WHEREAS, **RESIDENCY AND FELLOWSHIP PROGRAMS ACCREDITED BY** the Accreditation Council for Graduate Medical Education (ACGME) **USE A VARIETY OF PROGRAMS TO DOCUMENT** case log**S** ~~system is an essential tool~~ for tracking procedural competencies of resident**S AND FELLOWS** ~~physicians in accredited training programs~~ (1); and

WHEREAS, some ACGME-accredited programs maintain Osteopathic Recognition (OR), an accreditation status that distinctly acknowledges the additional focus on Osteopathic Principles and Practice (OPP) in the training of residents or fellows (2); and

WHEREAS, OR requires residents and fellows to demonstrate ~~the~~ competency in all components of OPP, including demonstrating **KNOWLEDGE** ~~skill~~ of OMT **INTEGRATION (3)**; and

WHEREAS, currently there is no mechanism in ~~ACGME~~ **SOME** case log~~s~~ **PROGRAMS** for residents and fellows to document their use of OMT as procedural intervention, despite its importance in patient care and ~~Osteopathic~~ OR training; and

WHEREAS, the inability to log OMT procedures limits the ability of ~~Osteopathic~~ **OR** residents and fellows to formally track their procedural experience, impairs program directors' ability to assess competency, and devalues the role of ~~Osteopathic medicine~~ **OMT** within ACGME **OR** training programs; and

~~WHEREAS, previous efforts to request ACGME to incorporate OMT into case logs have been met with resistance, further exacerbating concerns about equitable recognition of Osteopathic competencies within the single accreditation system; and, now therefore be it:~~

WHEREAS, SOME HOSPITAL CREDENTIALING PROCESSES REQUIRE PROCEDURAL LOGS OF OMT IN ORDER TO INITITALLY PRIVILEGE A PHYSICIAN TO PERFORM OMT IN THE HOSPITAL SETTING; AS SUCH THE INABILITY TO LOG OMT PROCEDURES DURING RESIDENCY OR FELLOWSHIP MAY HINDER A PHYSICIAN WHO SEEKS OMT HOSPITAL PRIVILEGES AFTER RESIDENCY OR FELLOWSHIP; AND, THEREFORE BE IT

RESOLVED, that the American Osteopathic Association (AOA) advocate ~~for the inclusion of Osteopathic Manipulative Treatment (OMT) procedures within the Accreditation~~

~~Council for Graduate Medical Education (ACGME) case log system, ensuring residents and fellows, particularly those in Osteopathic Recognized programs, have the capacity to log their procedural experiences in OMT; and be it further~~**THAT RESIDENCY AND FELLOWSHIP PROGRAMS UTILIZE A CASE LOG SYSTEM THAT ALLOWS OMT PROCEDURES TO BE TRACKED.**

~~RESOLVED, that upon successful passage, a copy of this resolution be submitted to the AOA for consideration at the 2025 AOA House of Delegates.~~

References:

1) ACGME case logs. Accreditation Council for Graduate Medical Education. 11 Feb, 2025. doi: https://www.acgme.org/data-systems-technical-support/case-log-system/
2) ACGME Osteopathic Recognition Standards. Accreditation Council for Graduate Medical Education. 2022, March 21. *doi*: https://www.acgme.org/globalassets/pfassets/programrequirements/801_osteopathicrecognition_2021v2.pdf
3) **ACGME OSTEOPATHIC RECOGNITION MILESTONES. ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION. 2022, JULY 12, 2025.** ***doi*:** https://www.acgme.org/globalassets/pdfs/milestones/osteopathicrecognitionmilestones.pdf

Background Information: Provided by AOA Staff
The ACGME Case Log System is a web application within Accreditation Data System (ADS) where residents and fellows (in certain specialties) are required to log their clinical experiences on an individual case basis. Depending on the specialty, the components used to build these cases are Common Procedural Terminology (CPT) codes, International Classification of Diseases (ICD9) codes, and/or descriptors.
Report of specialties that use Case Logs

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: SUPPORT OF OSTEOPATHIC **DISTINCTIVENESS IN** ~~RECOGNITION AND THE INTEGRITY OF~~ OSTEOPATHIC **RESIDENCY** TRAINING

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, Osteopathic Recognition (OR) is an accreditation status with the Accreditation
2 Council for Graduate Medical Education (ACGME) that distinctly acknowledges
3 programs that provide structured training on osteopathic principles and practice and
4 the tenets of osteopathic medicine in graduate medical education (GME) [1]; and
5
6 WHEREAS, the OR-Review Committee with the ACGME outlines specific standards for
7 achieving OR status [1]; and
8
9 WHEREAS, to date, the number of programs that have achieved OR is far smaller than the
10 number of programs previously accredited by the American Osteopathic Association
11 before the establishment of the Single Accreditation System (SAS) with the ACGME
12 [2,3]; and
13
14 WHEREAS, the American Association of Colleges of Osteopathic Medicine (AACOM)
15 published in August of 2024 the results of a study on the barriers to achieving
16 Osteopathic Recognition, with hopes that the results would drive ideas/methods to
17 overcome these barriers [4]; and
18
19 WHEREAS, some successful OR programs have already demonstrated viable models of
20 maintaining and expanding high-quality osteopathic training [5]; and
21
22 WHEREAS, the American Osteopathic Association (AOA) and the American Association of
23 Colleges of Osteopathic Medicine (AACOM) have the responsibility to safeguard
24 and promote the integrity of osteopathic training and education; ~~and,~~ now therefore
25 be it~~:~~
26
27 RESOLVED, the American Osteopathic Association (AOA) encourages ~~all~~ osteopathic
28 training in graduate medical education and strongly supports Accreditation Council
29 for Graduate Medical Education (ACGME) Osteopathic Recognition as the gold
30 standard for graduate medical education programs seeking to provide
31 comprehensive osteopathic training; and be it further
32
33 RESOLVED, the AOA works collaboratively with the **AMERICAN** Association of Colleges
34 of Osteopathic Medicine (AACOM) to identify and promote successful models of
35 Osteopathic Recognition, provide guidance and resources to programs seeking
36 recognition to ensure the continued strength and growth of osteopathic education
37 and training in graduate medical education; and be it further

38
39 RESOLVED, **THAT THE AMERICAN OSTEOPATHIC ASSOCIATION EXPLORE AND**
40 **EVALUATE ALTERNATIVE MECHANISMS TO THE CURRENT OSTEOPATHIC**
41 **RECOGNITION PROCESS IN ORDER TO BROADEN AND ENHANCE**
42 **EXPOSURE TO OSTEOPATHIC PRINCIPLES, PRACTICE AND PHILOSOPHY**
43 **FOR ALL RESIDENTS IN GRADUATE MEDICAL EDUCATION REGARDLESS**
44 **OF PROGRAM ACCREDITATION STATUS OR RECOGNITION**
45 **DESIGNATION.**~~that a copy of this resolution be submitted to the AOA for~~
46 ~~consideration at the 2025 AOA House of Delegates~~.

References:

1. ACGME Osteopathic Recognition Standards. Accreditation Council for Graduate Medical Education. 2022, March 21. *doi*: https://www.acgme.org/globalassets/pfassets/programrequirements/801_osteopathicrecognition_2021v2.pdf
2. Former AOA Programs that have Transitioned to the ACGME Accreditation. American Osteopathic Association. Accessed Aug 8th, 2023. *doi:* https://osteopathic.org/index.php?aam-media=/wp-content/uploads/2018/02/single-gme-transitioned -program-opportunities.pdf
3. List of Programs for or and with Osteopathic Recognition. Accreditation Council for Graduate Medical Education. Accessed on 24 Feb 2025. *doi:* http://apps.acgme.org/ads/Public/Reports/ReportRun.
4. American Association of Colleges of Osteopathic Medicine (AACOM). Aug 21, 2024. Landmark Study Answers Question: What's Next for Osteopathic Recognition?. *doi* https://www.aacom.org/news-reports/news/2024/08/21/landmark-study-answers-question---what-s-next-for-osteopathic-recognition
5. Eilerman, Andrew, Porter, Chas, Faherty, Mallory and Zmuda, Elizabeth. "Effectiveness of a program director for osteopathic medical education to support osteopathic recognition at a training site with multiple programs" *Journal of Osteopathic Medicine*, 2025. https://doi.org/10.1515/jom-2023-0253

Background Information: Provided by AOA Staff

Current AOA Policy:
H202-A/20 Directors of Medical Education Overseeing Osteopathic Postdoctoral Training Programs
H618-A/23 Osteopathic Graduate Medical Education

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _*Referred to Ohio Osteopathic Association*____

DATE: ____July 19, 2025________________

SUBJECT: OSTEOPATHIC MEDICAL STUDENT ~~AUDITION~~ ROTATIONS

SUBMITTED BY: Osteopathic Physicians and Surgeons of California

REFERRED TO: Committee on Educational Affairs

WHEREAS, Osteopathic Medical Students, **(OMS)** ~~in their fourth year (OMS IV),~~ participate in ~~audition~~ **CLINICAL** rotations**, AS PART OF THEIR EDUCATIONAL PROGRAM** ~~during which they showcase their skills for residency placement~~; and

~~WHEREAS, individual residency programs are eligible to host OMS IV students, either directly or through the Visiting Student Learning Opportunities (VSLO) platform; and~~

WHEREAS, passing the Comprehensive Osteopathic Medical Licensing Exam (COMLEX) Level 1 and Level 2 is recognized as the standard for osteopathic medical students to graduate; and

WHEREAS, the National Board of Osteopathic Medical Examiners (NBOME) has made significant gains in achieving COMLEX to be recognized, by residency program leadership, in many specialties, as sufficient when assessing OMS IV student academic records; and

WHEREAS, some individual ~~residency programs~~ **HOSPITALS AND CLINICAL TRAINING SITES** still require a passing United States Licensing Exam (USMLE) Step 1 and/or Step 2 score as a prerequisite for being approved for ~~an audition or VSLO~~ rotation; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) opposes any policy that requires an OMS ~~IV student~~ to demonstrate a United States Licensing Exam (USMLE) Step 1 and/or Step 2 passing score in order to be eligible for ~~an audition~~ **HOSPITAL OR CLINICAL TRAINING SITE** rotation ~~at a residency program;~~ and, be it further

RESOLVED, that the AOA ~~work with~~ **ENCOURAGE** all relevant stakeholders to ~~seek changes in~~ **ADDRESS** institutional ~~or residency program~~ policies and/or practices **WHICH** in order **REFLECT FAIR AND EQUITABLE CRITERIA IN THE SELECTION OF OSTEOPATHIC MEDICAL STUDENTS** ~~to continue to reduce barriers for OMS IV students~~ to ~~enter audition~~ **PARTICIPATE IN** rotations.

Background Information: Provided by AOA Staff
Current AOA Policy:
H214-A/20 Audition Rotations for Osteopathic Medical Students
H345-A/23 AOA Support for GME Equity
H348-A/24 GME Equity Annual Report 2024

Prior HOD action on similar or same topic:
H231-A/19 Recognition of COMLEX and USMLE as Equal Licensing Examinations Among Residency Programs

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: GME EQUITY ANNUAL REPORT - SOURCE: H345-A/23

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Educational Affairs

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1 WHEREAS, the 2023 House of Delegates adopted Policy H345-A/23 – AOA
2 Support for GME Equity; and

3 WHEREAS, Policy H345-A/23 – AOA Support for GME Equity requires the AOA
4 Board of Trustees to provide a report to the House of Delegates; now
5 therefore be it
6
7 RESOLVED, that the 2025 House of Delegates accept the AOA Board of Trustees
8 GME Equity 2025 Annual Report as outlined.

9 2025 GME Equity Annual Report
10
11 As the professional home for over 38,000 osteopathic medical students and 31,000
12 osteopathic residents and fellows, the American Osteopathic Association (AOA)
13 remains steadfast in its commitment to identifying and addressing systemic barriers
14 that hinder equitable access to graduate medical education opportunities for the
15 osteopathic medical profession. Throughout the year, the AOA continued its
16 collaborative efforts with the American Association of Colleges of Osteopathic
17 Medicine (AACOM) and the National Board of Osteopathic Medical Examiners
18 (NBOME) to promote universal acceptance of the COMLEX-USA licensing exam,
19 advocate for equitable evaluation of DO applicants, reduce systemic biases in
20 medical training environments, and advance recognition of osteopathic credentials
21 across all levels of medical education. AOA leaders remain active participants in the
22 Joint Osteopathic Organization Leadership coalition, which meets regularly to
23 address shared priorities including student parity, professional advocacy, and the
24 future of osteopathic medical education.
25
26 In March 2025, the AOA, in continued partnership with the AACOM, convened a
27 second annual Student Parity Summit. AOA President Teresa A. Hubka, DO, and
28 CEO Kathleen S. Creason, MBA, led the meeting alongside leaders from national
29 organizations including the American Medical Association, the Association of
30 American Medical Colleges, the National Resident Matching Program, and for the
31 first time, the Accreditation Council for Graduate Medical Education. The summit
32 focused on the ongoing perception of bias against the DO degree in residency
33 selection, the need for comprehensive data to better understand and address
34 disparities, the development of immediate non-legislative strategies to improve
35 parity, and the pursuit of long-term sustainable solutions to ensure equal opportunity
36 for all medical students.

37 Following the Student Parity Summit, the AOA and AACOM submitted a letter to the
38 ACGME recommending specific modifications to the Common Program
39 Requirements and Sponsoring Institution Requirements aimed at addressing parity
40 challenges faced by osteopathic medical students during the transition to residency.
41 Additionally, the AOA, AACOM, and AAMC jointly sent a letter to the ACGME
42 proposing the formation of a working group comprised of stakeholder organizations
43 to celebrate successes, describe challenges, and identify opportunities to realize
44 the true value of single GME accreditation.
45
46 Increased data transparency from stakeholders has been a key request from the
47 AOA and the AACOM. This year, there has been an increase in available data on
48 osteopathic medical students' applications, interview, ranking, and matching trends.
49 From this data, the AOA has identified program directors' associations to increase
50 engagement in the coming months facilitated through our strong partnership with
51 the Council on Medical Specialty Societies (CMSS).
52
53 AOA staff and leadership also engaged directly with graduate medical education
54 stakeholders to address inequities reported by osteopathic medical students.
55 Through the dedicated do-discrimination@osteopathic.org inbox, the AOA
56 responded to dozens of student concerns related to access to audition rotations,
57 program acceptance of COMLEX-USA scores, and discriminatory language in
58 program materials or communications. The extent to which inequities against DOs
59 run afoul of the law is a state law issue and, as such, varies state by state.
60 For this reason, in November 2024, AOA presented to osteopathic state and
61 specialty affiliates on model state legislation the AOA has developed to support DO
62 parity and provided guidance to state affiliates on how to advocate for stronger
63 regulatory frameworks that protect and promote equitable treatment of osteopathic
64 medical students and physicians. These resources are available on the AOA's
65 affiliate workspace for easy access and the AOA remains ready to assist any state
66 affiliates through this process.
67
68 The AOA remains unwavering in its mission to eliminate barriers to graduate
69 medical education access and to ensure that all osteopathic medical students and
70 residents are evaluated fairly and equitably. Through continued collaboration,
71 advocacy, and education, the AOA is advancing a future where osteopathic medical
72 students and physicians have equal opportunities to thrive in medical training and
73 practice.

Background Information: Provided by AOA Staff
Current AOA Policy: AOA Support for GME Equity - Source: H345-A/23; 2024 GME Equity Annual Report - Source H348 A/24
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted__________
DATE: ___July 19, 2025_____________

300 Series
Professional Affairs
Resolutions

Actions

AMERICAN OSTEOPATHIC ASSOCIATION

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105th ANNUAL AOA HOUSE OF DELEGATES MEETING
2025 RESOLUTION ROSTER (300 SERIES)
As of 07-19-25

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
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	Reference Committee	Action
H-300	Site Neutral Reimbursement (SR-Source-H306-A/20)	BFHP	Professional Affairs	Adopted
H-301	Physician Office Laboratories (SR-Source-H312-A/20)	BFHP	Professional Affairs	Adopted
H-302	Uniformed Services: Endorsement of Physicians Serving in the Uniformed Services (SR-Source-H315-A/20)	BFHP	Professional Affairs	Adopted as Amended
H-303	Emergency Medical Services for Children – Support of (SR-Source-H316-A/20)	BFHP	Professional Affairs	Adopted
H-304	Medicare Balance Billing (SR-Source-H319-A/20)	BFHP	Professional Affairs	Adopted
H-305	Adverse Childhood Experiences Screening (SR-Source-H327-A/20)	BFHP	Professional Affairs	Adopted
H-306	Inequalities in Medicaid Funding Affecting U.S. Territories (SR-Source-H329-A/20)	BFHP	Professional Affairs	Adopted
H-307	Protecting American Students from Profit-Driven Foreign Medical Schools (SR-Source-H302-A/20)	BFHP	Professional Affairs	Adopted as Amended
H-308	Osteopath and Osteopathy - Use of the term (SR-Source-H310-A/20)	BIOM	Professional Affairs	Adopted as Amended
H-309	Postgraduate Compensation (SR-Source-H313-A/20)	BOE	Professional Affairs	Adopted as Amended
H-310	Low Back Pain Clinical Practice Guidelines, Revision of (SR-Source-H325-A/20)	BORPH	Professional Affairs	Referred to BORPH
H-311	Intentionally Blank			
H-312	Retail-Based Health Clinics and Urgent Care Centers (SR-Source-H301-A/20)	BORPH	Professional Affairs	Adopted as Amended
H-313	Second Opinion, Surgical Cases (SR-Source-H314-A/20)	CERA	Professional Affairs	Adopted as Amended
H-314	Buprenorphine Maintenance Treatment Insurance Coverage (SR-Source-H323-A/20)	CERA	Professional Affairs	Adopted as Amended

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105th ANNUAL AOA HOUSE OF DELEGATES MEETING
2025 RESOLUTION ROSTER (300 SERIES)
As of 07-19-25

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-315	Tax Credit for Precepting (SR-Source-H305-A/20)	CSHA	Professional Affairs	Adopted
H-316	Practice Rights of Osteopathic Physicians (SR-Source-H308-A/20)	CSHA	Professional Affairs	Adopted as Amended
H-317	Physician Incentives to Underserved Areas (SR-Source-H317-A/20)	CSHA	Professional Affairs	Adopted as Amended
H-318	Violence against Healthcare Staff (SR-Source-H324-A/20)	CSHA	Professional Affairs	Adopted
H-319	CDC Guideline for Prescribing Opioids for Chronic Pain - United States (SR- Source-H337-A/20)	CSHA	Professional Affairs	Adopted as Amended
H-320	Use of the Term “Physician” “Doctor” and “Provider” (SR-Source-H336-A/20)	CSHA	Professional Affairs	Adopted as Amended
H-321	Support for OMT Privileges (SR-Source H349-A/19; Referred H335-A/24)	BOE	Professional Affairs	Adopted as Amended
H-322	End-of-Life Care-Use of Placebos (SR-Source H322-A/19; Referred H310-A/24)	BORPH	Professional Affairs	Referred to BORPH
H-323	Marijuana & THC – Unintentional Pediatric Ingestion Prevention	MAOPS (Missouri)	Professional Affairs	Adopted as Amended
H-324	Marijuana Cessation Counseling Reimbursement	ACOFP	Professional Affairs	Adopted as Amended
H-325	Rural Hospital Funding	IOMA (Iowa)	Professional Affairs	Adopted as Amended
H-326	Pharmacy Benefit Managers (PBMS)	IOMA (Iowa)	Professional Affairs	Referred to IOMA
H-327	Support for Methods to Increase the Compensation for Pediatricians to Address Future Workforce Challenges	OOA (Ohio)	Professional Affairs	Adopted as Amended
H-328	Definition of Osteopathic Physician	OPSC (California)	Professional Affairs	Adopted
H-329	AOA Program Participants and Awards Criteria Policy	BOT	Professional Affairs	Adopted as Amended

SUBJECT: SITE NEUTRAL REIMBURSEMENT - SOURCE: H306-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant and now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 Policy Statement

8 The American Osteopathic Association (AOA) supports that payments from all
9 payers should reflect the resources required to provide patient care in each setting.

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

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

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

25 The AOA supports that Medicare patients should be provided access to data
26 regarding differences in copayment requirements among various sites of service.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted________

DATE: _____July 19, 2025__________

SUBJECT: PHYSICIAN OFFICE LABORATORIES - SOURCE: H312-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports the development and
8 expansion of Waived Physician Office Laboratory testing and will work to ensure
9 that physician office laboratory certification be as non-intrusive into the practice of
10 medicine as possible; and will seek assurances that access to any laboratory tests
11 deemed medically necessary by the physician, not be limited by unnecessary
12 regulations.

Background Information: Provided by AOA Staff
Current AOA Policy: 1990; 1995 Reaffirmed as Amended; 2000 Reaffirmed, 2005 Reaffirmed; 2010 Reaffirmed; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_________

DATE: _____July 19, 2025___________

SUBJECT: UNIFORMED SERVICES: ENDORSEMENT OF PHYSICIANS SERVING IN THE UNIFORMED SERVICES - SOURCE: H315-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) will continue to assist the Surgeons
8 General of the uniformed services, **THE DIRECTOR OF THE DEFENSE HEALTH**
9 **AGENCY,** and the American public in maintaining and assuring the highest quality
10 of healthcare by its representatives in the uniformed services and recognizes **MAY**
11 **3rd AS** the annual anniversary of osteopathic physicians being commissioned in the
12 military.

Background Information: Provided by AOA Staff
Current AOA Policy: 1985; 1990 Reaffirmed as Amended; 1995 Reaffirmed; 2000 Reaffirmed; 2005 Reaffirmed; 2010 Revised; 2015 Revised; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: EMERGENCY MEDICAL SERVICES FOR CHILDREN – SUPPORT OF - SOURCE: H316-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports the availability to state of
8 the art emergency medical care for ill and injured children and adolescents; that
9 pediatric services are well integrated into an emergency medical service system
10 backed by optimal resources; and the entire spectrum of emergency services,
11 including primary prevention of illness and injury, acute care, and rehabilitation, are
12 provided to children and adolescents as well as adults, no matter where they live,
13 attend school or travel. The federal Emergency Medical Services for Children
14 (EMSC) program achieves these goals and as such, AOA supports full funding and
15 reauthorization of this program when needed.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005, 2010 Reaffirmed; 2015 Reaffirmed as Amended; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted_____________

DATE: ____July 19, 2025_____________

SUBJECT: MEDICARE BALANCE BILLING - SOURCE: H319-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports enactment of federal
8 legislation that promotes equitable balance billing practices within Medicare that
9 facilitate continued physician participation in Medicare.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: ADVERSE CHILDHOOD EXPERIENCES SCREENING - SOURCE: H327-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) encourages the inclusion of Adverse
8 Childhood Experiences (ACEs) screenings in primary care settings.

Background Information: Provided by AOA Staff
Current AOA Policy: 2020 Adopted as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_________

DATE: ____July 19, 2025_____________

SUBJECT: INEQUALITIES IN MEDICAID FUNDING AFFECTING U.S. TERRITORIES - SOURCE: H329-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports an increase in or removal of
8 the federal funding cap on territorial Medicaid programs, thereby reducing costs and
9 preventing the cost-reducing measures that negatively impact the quality of and
10 access to healthcare of low-income U.S. citizens and U.S. nationals living on the
11 U.S. territories; and, that the AOA supports changing the territorial Federal Medical
12 Assistance Percentage formula so that it considers per capita income, thereby
13 tailoring the federal matching rate to each population's financial needs.

Background Information: Provided by AOA Staff
Current AOA Policy: 2020 Adopted as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: PROTECTING AMERICAN STUDENTS FROM PROFIT-DRIVEN FOREIGN MEDICAL SCHOOLS - SOURCE: H302-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

WHEREAS, the Bureau on Federal Health Programs believes that the policy remains relevant now, therefore be it

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

The American Osteopathic Association (AOA) ~~will officially adopt~~ and advocate**S** 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.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: OSTEOPATH AND OSTEOPATHY - USE OF THE TERM - SOURCE: H310-A/20

SUBMITTED BY: Bureau of International Osteopathic Medicine

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of International Osteopathic Medicine has reviewed the
3 policy; and

4 WHEREAS, the Bureau of International Osteopathic Medicine believes that the
5 policy remains relevant now, therefore be it

6 RESOLVED, that the Bureau of International Osteopathic Medicine recommends
7 that the following policy be REAFFIRMED AS AMENDED**.**

8 The American Osteopathic Association (AOA) policy both officially in our
9 publications and individually on a conversational basis, is to preferentially use the
10 term “osteopathic physician” in place of the word “osteopath” and the term
11 “osteopathic medicine” in place of the word “osteopathy;” and that the words
12 “osteopath” and “osteopathy” be reserved in the United States for the following
13 purposes:

14 (1) previously named entities within the osteopathic medical profession;

15 (2) historical, sentimental, and informal discussions; and

16 ~~(3) osteopaths with a limited scope of practice.~~

Background Information: Provided by AOA Staff
Current AOA Policy: 1994; 2000 Reaffirmed; 2005 Reaffirmed as Amended; 2010 Reaffirmed as Amended; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: POSTGRADUATE COMPENSATION - SOURCE: H313-A/20

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy;

3 WHEREAS, the Bureau of Osteopathic Education has provided amendments to
4 provide clarity and updates to the policy, now therefore be it

5 RESOLVED, that the Bureau of Osteopathic Education recommends that the
6 following policy be REAFFIRMED AS AMENDED.

7 The American Osteopathic Association (AOA) affirms its support for enhancing the
8 quality of ~~teaching~~ **MEDICAL TRAINING** programs, and urges Congress to provide
9 more equitable graduate medica education funding ~~so~~ **FOR** hospitals and ~~other~~
10 healthcare delivery systems OF **VARIED SETTINGS, LOCATIONS, SIZE, AND**
11 **DEMOGRAPHIC POPULATIONS TO** ~~can~~ provide competitive compensation for
12 postgraduate training.

Background Information: Provided by AOA Staff
Current AOA Policy: 1990; 1995 Reaffirmed as Amended; 2000 Reaffirmed, 2005 Reaffirmed as Amended; 2010 Reaffirmed; 2015; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: LOW BACK PAIN CLINICAL PRACTICE GUIDELINES, REVISION OF - SOURCE: H325-A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH) continues
3 to search for current published systematic reviews on which to base a revision of
4 these guidelines, and is now completing a literature review to publish which will
5 supplement the guidelines but will not be completed prior to the 2025 HOD
6 meeting; and

7 WHEREAS, a BORPH task force will update the guidelines over the next year using the
8 published literature review; and

9 WHEREAS, the BORPH desires to reaffirm this policy as it shall be amended, therefore
10 be it

11 RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends
12 that the following policy be REAFFIRMED, and be it further

13 RESOLVED, to postpone the review of H325-A2020 for one year and bring back to the
14 House of Delegates in 2026 for sunset review and approval pending a literature
15 review and revision of the guidelines.

16 The American Osteopathic Association (AOA) approves the attached Guidelines for Patients
17 with Low Back Pain.

18 American Osteopathic Association Guidelines for
19 Osteopathic Manipulative Treatment (OMT) for Patients with Low Back Pain
20
21 Executive Summary:
22 The American Osteopathic Association (AOA) recommends that osteopathic physicians use
23 Osteopathic manipulative treatment (OMT) in the care of patients with low back pain. Evidence
24 from systematic reviews and meta-analyses of randomized clinical trials (Evidence Level 1a)
25 supports this recommendation.
26 1. Overview material: Provide a structured abstract that includes the guideline's release
27 date, status (original, revised, updated), and print and electronic sources.

28 The current guidelines are available through the AOA web site and National Guidelines
29 Clearinghouse, AHRQ. The guideline is partially based upon the following study:

30 Franke H, Franke J-D, Fryer G. Osteopathic manipulative treatment for nonspecific low back
31 pain: a systematic review and meta-analysis. BMC Musculoskeletal Disorders 2014, 15:286
32 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.

1. 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

184 tears or lacerations; spinal or vertebral joint ligament rupture; inflammation of intervertebral
185 discs, spinal zygapophyseal facets joints, muscles or fascia; skin lacerations; sacroiliitis;
186 ankylosing spondylitis; or masses in or from the low back structures that are the source of the
187 pain. Exclusion from this guideline does not imply that OMT is contraindicated in these
188 conditions.

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

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

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

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

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

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

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

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

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

231 Franke et al[2] evaluated the methodological quality of the studies using the Risk of Bias tool of
232 the Cochrane Back Review Group. Studies were scored as 'low risk', 'high risk', or 'unclear',

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

241 Franke et al conducted other noteworthy analysis. They used the standard mean difference
242 (SMD) was also used in a random effects model to determine functional status. The authors
243 grouped the 1 study examining acute LBP and the 3 studies examining patients with both
244 acute and chronic LBP together for the purpose of their meta-analyses. Overall, they created
245 four groups: (1) acute and chronic LBP; (2) chronic LBP (duration of pain more than 3 months);
246 (3) LBP in pregnant women; and (4) LBP in postpartum women.

247

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

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

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

257

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

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

269 **OMT versus other interventions for chronic nonspecific low back pain**
270 For nonspecific LBP, Franke et al[2] analyzed 6 studies with 7 comparisons and 769 participants.
271 This analysis revealed moderate-quality evidence that a significant difference in favor of OMT
272 existed (MD:-14.93, 95%CI:-25.18 to −4.68)

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

277 **OMT versus usual obstetric care, sham ultrasound, and untreated for nonspecific low**
278 **back pain in pregnant women**
279 For LBP in pregnant women, the authors reviewed three studies with 4 comparisons and 242
280 participants. Two studies showed a significant improvement following OMT, and 1 study
281 showed a non-significant improvement. The final analysis of these studies resulted in low-
282 quality evidence for a significant difference in favor of OMT for LBP in pregnant women (MD,

283 −23.01; 95% CI, −44.13 to −1.88) and functional status (SMD, −0.80; 95% CI, −1.36 to −0.23).[2]

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

288

289 **OMT versus untreated for nonspecific low back pain in postpartum women**

290 Franke et al reviewed two studies focusing on OMT for LBP in postpartum women. Both
291 studies reported significant improvement following OMT. The moderate-quality evidence
292 showed a significant difference in favor of OMT for pain (MD, −41.85; 95% CI, −49.43 to
293 −34.27) and functional status (SMD, −1.78; 95% CI, −2.21 to −1.35).

294 **DISCUSSION**

295 Efficacy of OMT

296 The overall results clearly demonstrate a statistically significant reduction in low back pain with
297 OMT. Subgroup meta-analyses to control for moderator variables demonstrated that OMT
298 significantly reduced low back pain vs active treatment or placebo control and vs no treatment
299 control. If it is assumed, as shown in a review[18], that the effect size is –0.27 for placebo control
300 vs no treatment in trials involving continuous measures for pain, then the results of our study
301 are highly congruent (i.e., effect size for OMT vs no treatment [–0.53] = effect size for OMT vs
302 active treatment or placebo control [–0.26] + effect size for placebo control vs no treatment [–
303 0.27]). It has been suggested that the therapeutic benefits of spinal manipulation are largely
304 due to placebo effects.[19] A preponderance of results from our sensitivity analyses supports the
305 efficacy of OMT vs active treatment or placebo control and therefore indicates that low back
306 pain reduction with OMT is attributable to the manipulation techniques, not merely placebo
307 effects.

308

309 Also, as indicated above, OMT vs no treatment control demonstrated pain reductions twice as
310 great as previously observed in clinical trials of placebo vs no treatment control.[18] The clinical
311 significance of our findings is readily evident when compared with nonsteroidal anti-
312 inflammatory drugs, including cyclo-oxygenase-2 inhibitors. A recent meta-analysis of the
313 efficacy of these drugs included 23 randomized placebo controlled trials for osteoarthritic knee
314 pain, representing over 10,000 subjects, and measured pain outcomes up to three months
315 following randomization.[20] This study found an overall effect size of –0.32 (95% CI, –0.24 - –
316 0.39) and effect size of –0.23 (95% CI, –0.16 - –0.31) when drug non-responders were not
317 excluded from the analyses. Thus, our effect size of –0.26 (95% CI, –0.48 - –0.05) for OMT in
318 trials vs active treatment or placebo control suggests that OMT provides an analgesic effect
319 comparable to nonsteroidal anti-inflammatory drugs, including cyclo-oxygenase-2 inhibitors.

320

321 Unlike the meta-analysis of nonsteroidal anti-inflammatory drugs,[20] however, Licciardone et al
322 found that OMT also significantly reduced pain during the three to 12 month period following
323 randomization.[21] Thus, OMT for low back pain may eliminate or reduce the need for drugs that
324 can have serious adverse effects.[22] Because osteopathic physicians provide OMT to
325 complement conventional treatment for low back pain, they tend to avoid substantial additional
326 costs that would otherwise be incurred by referring patients to chiropractors or other
327 practitioners.[23]With regard to back pain, osteopathic physicians make fewer referrals to other
328 physicians and admit a lower percentage of patients to hospitals than allopathic physicians,[3]
329 while also treating back pain episodes with substantially fewer visits than chiropractors.[24]
330 Although osteopathic family physicians are less likely to order radiographs or prescribe
331 nonsteroidal anti-inflammatory drugs, aspirin, muscle relaxants, sedatives, and narcotic
332 analgesics for low back pain than their allopathic counterparts, osteopathic physicians have a
333 substantially higher proportion of patients returning for follow-up back care than allopathic
334 physicians.[25] In the United Kingdom, where general practitioners may refer patients with spinal
335 pain to osteopaths for manipulation, it has been shown that OMT improved physical and

336 psychological outcomes at little extra cost.[26]

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

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

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

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

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

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

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

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

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

362
363

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.
364 How to Practice and Teach EBM (3rd ed), 2005

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

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

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

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

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

379 Once a patient with low back pain is diagnosed with somatic dysfunction as the cause, or
380 contributing factor, of the low back pain, OMT should be utilized by the osteopathic physician.
381 The diagnosis of somatic dysfunction entails a focal or complete history and physical exam,
382 including an osteopathic structural exam that provides evidence of asymmetrical anatomical
383 landmarks, restriction or altered range of joint motion, and palpatory abnormalities of soft
384 tissues. OMT to treat somatic dysfunction is utilized after other potential causes of low back
385 pain are ruled out or considered improbable by the treating physician; i.e., vertebral fracture;
386 vertebral joint dislocation; muscle tears or lacerations; spinal or vertebral joint ligament rupture;

387 inflammation of intervertebral discs, spinal zygapophyseal facets joints, muscles or fascia; skin
388 lacerations; sacroiliitis; ankylosing spondylitis; masses in or from the low back structures; or
389 organic (visceral) disease referring pain to the back or causing low back muscle spasms.

390 **NOTE FROM STAFF: PLEASE GO TO PAGE 20 TO VIEW ALGORITHM.**

391

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

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

References:

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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)
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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.
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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.

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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* **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

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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.

Source: H325-A/20

Background Information: Provided by AOA Staff
Current AOA Policy: 2009; 2014 Referred; 2015 Reaffirmed as Amended; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: none

FISCAL IMPACT: $0

ACTION TAKEN: _*Referred to Bureau of Osteopathic Research & Public Health*______

DATE: ____July 19, 2025____________

Copied from AOA Task Force on the Low Back Pain Clinical Practice Guidelines. *American Osteopathic Association Guidelines for Osteopathic Manipulative Treatment (OMT) for Patients With Low Back Pain.* J Am Osteopath Assoc. 2016;116(8):536-549. doi:10.7556/jaoa.2016.107

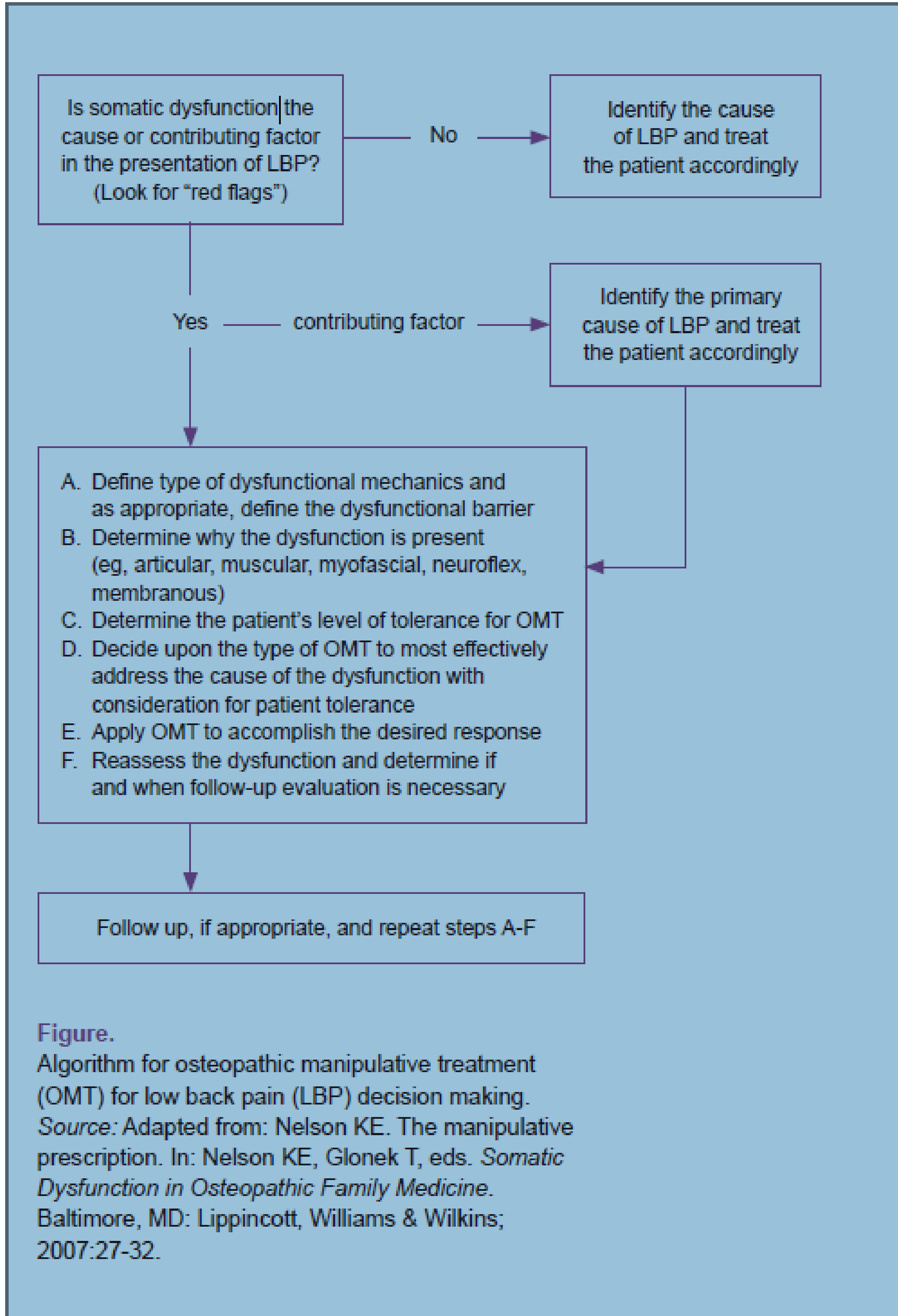

Figure.
Algorithm for osteopathic manipulative treatment (OMT) for low back pain (LBP) decision making. *Source:* Adapted from: Nelson KE. The manipulative prescription. In: Nelson KE, Glonek T, eds. *Somatic Dysfunction in Osteopathic Family Medicine.* Baltimore, MD: Lippincott, Williams & Wilkins; 2007:27-32.

SUBJECT: RETAIL-BASED HEALTH CLINICS AND URGENT CARE CENTERS - SOURCE: H-301/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be Reaffirmed as Amended.

8 The American Osteopathic Association (AOA) recommends that retail-based health
9 clinics and urgent care centers adhere to the following principles and standards to
10 guide their establishment and operation.
11

12 1. Retail-based health clinics and urgent care centers must establish arrangements
13 by which their health care practitioners have direct access to and supervision by
14 physicians at levels that meet or exceed respective state laws.
15 2. Retail-based health clinics and urgent care centers must encourage patients to
16 establish care with a primary care physician to ensure continuity of care. If a
17 patient's conditions or symptoms are beyond the scope of services provided by
18 the clinic, that patient must immediately be referred to an appropriate physician
19 or emergency facility. Also, retail-based health clinics **AND** urgent care centers
20 should be encouraged to use electronic health records as a means of
21 communicating information with the patient's primary physician and facilitating
22 continuity of care.
23 3. Whether by electronic communication, or some other acceptable means, retail-
24 based health clinics **AND** urgent care centers must send detailed information on
25 services provided to the patient's primary care physician in a timely manner to
26 ensure continuity of care.
27 **4.** The clinic must have a well-defined and limited scope of clinical services. These
28 services must not exceed the on-site health provider's scope of practice, as
29 determined by state law. **IF A LISCENSED PHYSICIAN IS NOT ONSITE, IT**
30 **MUST BE CLEARLY POSTED.**
31 5. Retail-based health clinics **AND** urgent care centers must use standardized
32 medical protocols developed from evidence-based practice guidelines for non-
33 physician practitioners.

34 6. Retail-based healthcare clinics **AND** urgent care centers must comply with all
35 applicable standards of state and federal regulations expected of physician
36 offices.
37 7. Retail-based healthcare clinics and urgent care centers must not expand into
38 programs offering patient care for the management of chronic and complex
39 conditions.
40 8. Retail-based healthcare clinics located in or affiliated with a pharmacy must
41 inform patients that any medication prescribed or recommended may be
42 purchased at the patient's pharmacy of choice.

Background Information: Provided by AOA Staff
Current AOA Policy: 2006; 2011 Reaffirmed as Amended; 2015 Revised; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: ___July 19, 2025______________

SUBJECT: SECOND OPINION, SURGICAL CASES – SOURCE: H314-A/20

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED

6 The American Osteopathic Association (AOA) believes that ~~AOA members~~
7 **OSTEOPATHIC PHYSICIANS** who are board certified, or board eligible and
8 qualified by their training and experience to render a second surgical opinion in any
9 given case, be recognized and utilized as qualified and reimbursed by entities
10 underwriting such opinions and that this policy statement in no way advocates the
11 institution of any mandatory second surgical opinion programs, by any entity.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above, 1980; 1985 Reaffirmed as Amended; 1990 Reaffirmed; 1995 Reaffirmed; 2000 Reaffirmed as Amended; 2005 Reaffirmed as Amended; 2010 Reaffirmed as Amended; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: BUPRENORPHINE MAINTENANCE TREATMENT INSURANCE COVERAGE – SOURCE: H323-A/20

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED AS AMENDED

6 The American Osteopathic Association (AOA) recommends that ~~state Medicaid~~
7 ~~administrators~~ **PUBLIC AND PRIVATE PAYORS (1)** remove any arbitrary and
8 restrictive limits for buprenorphine coverage; and ~~that state Medicaid administrators~~
9 ~~and third party payers~~ **(2)** recognize that ~~**USING**~~ ~~chronic disease management~~
10 ~~**MEDICATION FOR**~~ **TREATMENT OF OPIOID USE DISORDER** includes a
11 combination of psychotherapeutic and pharmacological interventions that will yield
12 the best outcomes for ~~patients with opioid use disorder~~ **SUCH PATIENTS, WHEN**
13 **POSSIBLE.**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above, 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: TAX CREDIT FOR PRECEPTING - SOURCE: H305-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) will support legislation to implement
8 precepting tax credits.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted__________

DATE: _____July 19, 2025____________

SUBJECT: PRACTICE RIGHTS OF OSTEOPATHIC PHYSICIANS - SOURCE: H308-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant; now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

7 The American Osteopathic Association (AOA) and its component societies are
8 encouraged to support osteopathic physicians and their practices by:

9 (1) working with the American Osteopathic Information Association to educate
10 physicians as to the importance of compliance, risk management, and risk
11 agreements with managed care, billing and coding, documentation, and fraud and
12 abuse issues.

13 (2). Identifying supportive state and federal agencies, professional liability insurance
14 companies, and physicians with expertise on these issues.

15 (3) encouraging government agencies and insurance companies to utilize only
16 expert witnesses who are osteopathic physicians in peer review, fraud and abuse,
17 civil and criminal cases involving osteopathic physicians and boards with "like
18 osteopathic specialty".

19 (4) ~~AOA and state society leadership of~~ **IDENTIFYING** any needs, trends, or issues
20 of concern related to the above, which will enhance the rights and practices of our
21 fellow osteopathic physicians.

Background Information: Provided by AOA Staff
Current AOA Policy: 1999; 2004 Reaffirmed as Amended; 2009 Reaffirmed as Amended; 2015 Reaffirmed; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 19, 2025____________

SUBJECT: PHYSICIAN INCENTIVES TO **PRACTICE IN** UNDERSERVED AREAS - SOURCE: H317-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) will support federal and state
8 legislation to increase physician loan repayment programs and tax
9 deductions/credits for individuals who practice in underserved rural and urban
10 areas.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: VIOLENCE AGAINST HEALTHCARE STAFF
- SOURCE: H324-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

7 The American Osteopathic Association (AOA) supports legislation to hold patients
8 and their associates (that includes friends, family, and anyone who accompanies
9 them) accountable for physical assault and verbal threats to health care staff by
10 upgrading penalties under federal and relevant state law and legislation from
11 misdemeanors to felonies where applicable.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted____________

DATE: ____July 19, 2025______________

SUBJECT: CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR ~~CHRONIC~~ PAIN - UNITED STATES - SOURCE: H337-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant but requires updating to reflect recent changes; now, therefore be it

5 RESOLVED, the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED AS AMENDED**.**

7 The American Osteopathic Association (AOA) opposes the misuse and inflexible
8 application of the United States Centers for Disease Control and Prevention (CDC)
9 “Guideline for Prescribing Opioids for ~~Chronic~~ Pain — ~~United States, 2016,~~
10 ~~(Guideline)”~~ by law makers and regulators; and the AOA opposes the codification of
11 the Guidelines into law or regulation and their use as a measure of the
12 appropriateness of physicians prescribing.~~; and the AOA recommends physicians~~
13 ~~read and consider the use of the~~ ~~**2019 RECOMMENDATIONS OF THE AMERICAN**~~
14 ~~**MEDICAL ASSOCIATION OPIOID TASK FORCE AND THE CDC “CLINICAL**~~
15 ~~**PRACTICE GUIDELINE FOR PRESCRIBING OPIOIDS FOR PAIN — UNITED**~~
16 ~~**STATES, 2022”**~~ ~~2019 AMA Opioid Task Force 2019 Guidelines in patients being~~
17 ~~treated for non-malignant chronic pain conditions.~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2016; 2020 Adopted as Amended

Prior HOD action on similar or same topic: H322-A/20 Prescription Drug Diversion and Abuse – Education, Research, and Advocacy; H326-A/21 Pain Related Education Requirements; H345-A/24 Opioid Crisis, Causes; H431-A/22 AOA Policies on Opioids and Substance Use

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: ____July 19, 2025_____________

SUBJECT: USE OF THE TERM “PHYSICIAN” “DOCTOR” AND “PROVIDER”- SOURCE: H336-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Professional Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on State Health Affairs has reviewed the policy; and

WHEREAS, the Council on State Health Affairs believes that the policy remains relevant now, therefore be it

RESOLVED, that the Council on State Health Affairs recommends that the following policy be REAFFIRMED**.**

Use of the Term “Physician” “Doctor” and “Provider”

The American Osteopathic Association (AOA) adopts as policy:

(1) that ~~AOA members~~ **OSTEOPATHIC PHYSICIANS** 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) THAT AOA ADVOCATES FOR THE USE OF THE TERM “STUDENT PHYSICIAN” WHEN INTRODUCING OSTEOPATHIC MEDICAL STUDENTS IN CLINICAL SETTINGS, TO CLEARLY DISTINGUISH THEM FROM OTHER TYPES OF LEARNERS WITHIN THE HEALTHCARE ENVIRONMENT.

~~(2)~~ **(3) THAT AOA** supports the appropriate use of credentials and professional degrees in advertisements;

~~(3)~~ **(4) THAT AOA** supports providing a mechanism for physicians to report advertisements related to medical care that are false or deceptive;

~~(4)~~ **(5) THAT AOA** opposes non-physician clinicians’ use of the title “physician,” as well as use of the title “doctor” without specifying the type of doctorate received, because such communication is likely to confuse the public by implying that the non-physician clinician is engaged in the unlimited practice of medicine;

~~(5)~~ **(6) THAT AOA** opposes legislation that would expand the use of the term “physician” to persons other than US-trained DOs, and MDs; and

34 ~~(6)~~ **(7) THAT AOA** supports a policy that physicians and non-physician clinicians
35 should identify themselves to their patients using their degree in both a verbal
36 introduction as well as by other identification clearly visible during patient
37 encounters.

Background Information: Provided by AOA Staff
Current AOA Policy: 2009; 2014 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: SUPPORT FOR **OSTEOPATHIC MANIPULATIVE TREATMENT (**OMT**)** PRIVILEGES – SOURCE: H349-A/19

SUBMITTED BY: Bureau of Osteopathic Education / AOA Board of Trustees

REFERRED TO: Committee on Professional Affairs

WHEREAS, the Bureau of Osteopathic Education (BOE) submitted H335 A/24 Support for OMT Privileges (Source H349 A/19) to the 2024 House of Delegates and recommended that it be reaffirmed as amended; and

WHEREAS, the 2024 House of Delegates referred this policy back to BOE to include guidelines for credentialing if appropriate; and

WHEREAS, the BOE and President Hubka's CME Workgroup has reviewed the policy and sample credentialing guidelines; and

WHEREAS, the BOE has had significant discussions regarding this resolution at its November 2023, January 2024, April 2024, June 2024, September 2024, January 2025, and March 2025 meetings. The revisions to the policy are based on the 2015 credentialing document from the Department of the Navy Bureau of Medicine and Surgery; and

WHEREAS, consensus within the BOE could not be reached on the creation of separate guidelines "that standardize credentialing and privileging processes, including proctoring and approval of privileges to practice OMT." There was significant concern that the development of credentialing guidelines would have unintended consequences and create a mechanism for non-DOs to regulate OMT practice within medical systems and hospitals; and

WHEREAS, the BOE believes that their revisions to the policy provides guidance for **THE AMERICAN OSTEOPATHIC ASSOCIATION (**AOA**)** to advocate for all osteopathic physicians who desire to practice OMT within medical systems and hospitals. This is also consistent with current AOA **Osteopathic Manipulative Treatment (OMT) Coverage Determination Guidance** Source: H635 - A/20 "To perform OMT a qualified Doctor of Osteopathic Medicine must have graduated from an accredited school of osteopathic medicine or a medical doctor must have completed a board-approved postgraduate osteopathic training program that encompasses osteopathic principles and practices, including hands-on demonstration and competency testing in OMT"; and

WHEREAS, THE DEFINITION OF ~~OSTEOPATHIC MANIPULATIVE TREATMENT IS: OSTEOPATHIC MANIPULATIVE TREATMENT (~~OMT~~)~~ IS THE THERAPEUTIC APPLICATION OF MANUALLY GUIDED FORCES BY APPROPRIATELY TRAINED, FULLY LICENSED PHYSICIANS TO

IMPROVE PHYSIOLOGIC FUNCTION AND/OR SUPPORT HOMEOSTASIS THAT HAS BEEN ALTERED BY SOMATIC DYSFUNCTION.(1) SOMATIC DYSFUNCTION IS DEFINED AS "IMPAIRED OR ALTERED FUNCTION OF RELATED COMPONENTS OF THE BODY FRAMEWORK SYSTEM: SKELETAL, ARTHRODIAL AND MYOFASCIAL STRUCTURES, AND THEIR RELATED VASCULAR, LYMPHATIC AND NEURAL ELEMENTS." (1) OMT IS CONSIDERED SAFE WITH LOW RATES OF ADVERSE EVENTS (2); AND

WHEREAS, Osteopathic Manipulative Treatment is required curriculum for all Colleges of Osteopathic Medicine and assessed by the Comprehensive Osteopathic Medical Licensing Examination of the United States, ~~and~~ **NOW THEREFORE BE IT**;

~~WHEREAS, this guidance only refers to osteopathic physicians; a separate resolution should be developed if there is a desire to have policy for allopathic physicians; now, therefore be it~~

RESOLVED, that the BOE recommends that the following policy be REAFFIRMED AS AMENDED.

The American Osteopathic Association (AOA) **WILL** support and advocate for all **OSTEOPATHIC** physicians who desire to practice osteopathic manipulative treatment (OMT) within medical systems and hospitals; ~~and, that~~
~~The AOA create guidelines, that can be distributed upon request to hospitals, medical systems, and other interested entities, that standardize credentialing and privileging processes, including proctoring and approval of privileges to practice OMT~~.

DELINEATION OF CLINICAL PRIVILEGES

THE AOA HOLDS THAT GRADUATION FROM A COCA-ACCREDITED OSTEOPATHIC MEDICAL SCHOOL OR AN OSTEOPATHICALLY RECOGNIZED RESIDENCY PROGRAM PROVIDES SUFFICIENT FOUNDATIONAL COMPETENCY IN OMT. NEVERTHELESS, IT RECOGNIZES THAT CERTAIN HOSPITAL MEDICAL STAFF COMMITTEES OR PRIVILEGING BODIES MAY REQUIRE FURTHER EVIDENCE OR DOCUMENTATION TO DEMONSTRATE ONGOING COMPETENCY IN OMT, PARTICULARLY IN DIVERSE CLINICAL CONTEXTS.

THESE GUIDELINES, THEREFORE, SERVE AS AN ADVISORY RESOURCE, ASSISTING PRIVILEGING BODIES IN VERIFYING AND VALIDATING OMT PRIVILEGES WHILE RESPECTING THE UNIQUE AUTHORITY AND EXPERTISE OF OSTEOPATHIC PHYSICIANS TO GUIDE AND OVERSEE OMT CREDENTIALING.

THIS DOCUMENT SERVES TO PROVIDE EXAMPLE GUIDELINES AND IS NOT INTENDED TO SET A STANDARD FOR ANY INSTITUTION OR TO BE ALL-INCLUSIVE. IT REFLECTS THE AMERICAN OSTEOPATHIC ASSOCIATION

78 **(AOA) POLICY AND EMPHASIZES THE EXCLUSIVE AUTHORITY OF**
79 **OSTEOPATHIC PHYSICIANS IN GUIDING PRIVILEGING FOR OMT.**

80 **TRAINING OR EXPERIENCE CRITERIA FOR OMT PRIVILEGES:**

81 **1. GRADUATED FROM OSTEOPATHICALLY RECOGNIZED ACGME**
82 **RESIDENCY PROGRAM, OR GRADUATED FROM AN AOA OR ACGME**
83 **RESIDENCY PROGRAM AND PERFORMED OMT DURING RESIDENCY,**
84 **AND**
85 **2. PARTICIPATES IN AOA-ACCREDITED, OMT-SPECIFIC CONTINUING**
86 **MEDICAL EDUCATION COURSES, OR**
87 **3. DEMONSTRATES CONSISTENT AND ACTIVE PRACTICE OF OMT**
88 **(DOCUMENTED OR ATTESTED TO)**
89

90 **REFERENCES:**

91 **1. GIUSTI, REBECCA, EDITOR *THE GLOSSARY OF OSTEOPATHIC***
92 ***TERMINOLOGY*, 3RD EDITION. AMERICAN ASSOCIATION OF**
93 **COLLEGES OF OSTEOPATHIC MEDICINE, 2017.**
94 **2. DEGENHARDT, B. F., JOHNSON, J. C., BROOKS, W. J., & NORMAN, L.**
95 **(2018). CHARACTERIZING ADVERSE EVENTS REPORTED**
96 **IMMEDIATELY AFTER OSTEOPATHIC MANIPULATIVE TREATMENT. *THE***
97 ***JOURNAL OF THE AMERICAN OSTEOPATHIC ASSOCIATION, 118*(3),**
98 **141–149. HTTPS://DOI.ORG/10.7556/JAOA.2018.033**

99

Background Information: Provided by AOA Staff
Current AOA Policy: 2019; 2024 Referred

Prior HOD action on similar or same topic: H635-A/20- AOA Osteopathic Manipulative Treatment (OMT) Coverage Determination Guidance
H335-A/24- Referred to Bureau of Education

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: END-OF-LIFE CARE – USE OF PLACEBOS IN – SOURCE: H322-A/19

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH)
2 submitted H310-A/2024 SR END-OF-LIFE CARE – USE OF PLACEBOS IN-
3 H322-A/19 to the 2024 House of Delegates and recommended that it be
4 reaffirmed; and

5 WHEREAS, the 2024 House of Delegates referred this policy back to BORPH and
6 requested that BORPH update the language to use current terminology for
7 substance use disorders; and

8 WHEREAS, the policy was sent to the American Osteopathic Academy on Addiction
9 Medicine to review and update the language, now, therefore be it

10 RESOLVED, that the Bureau of Osteopathic Research and Public Health
11 recommends that the following policy be REAFFIRMED AS AMENDED.

12

13 Use of Placebos in End-of-Life Care
14
15 Position Paper
16
17 The AOA approves the attached position paper on Use of Placebos for Pain Management
18 in End-of-Life Care and will be updated according to the current literature.
19
20
21 USE OF PLACEBOS FOR PAIN MANAGEMENT IN END-OF-LIFE CARE
22
23 The placebo effect of medication can be a significant resultant action of any prescription.
24 However, the substitution of a placebo in place of effective pain medication has been
25 widely recognized as unethical, ineffective and potentially harmful. ([1-9]) A number of
26 organizations have advised against the use of placebo substitution, including the American
27 Pain Society, Agency for Healthcare Policy and Research, World Health Organization, the
28 Healthcare Facilities Accreditation Program, Joint Commission on Accreditation of
29 Healthcare Organizations, Education on End-of-Life Care Project (co-sponsored by the
30 American Medical Association), American Nursing Association, and the American Society
31 of Pain Management Nurses.
32

This white paper describes the literature and rationale in support of the AOA's position on the controversial subject of the use of placebos for pain management in terminally ill patients.

I. Definition of Terms

A. Placebo, placebo substitution, placebo effect and nocebo response

A placebo is a substance presumed to be pharmacokinetically inert. Placebo substitution means the substitution of a physiologically inactive substance for a comparison with the physiologically active substance. Placebo effect is the positive psychosomatic response of an individual to a treatment; in contrast, the nocebo response is a negative psychosomatic response to a treatment. ([10]) The placebo effect is an important adjunct in the treatment of symptoms. The alleviation of symptoms has an inherent positive psychological component; patients who perceive their symptoms to be relieved by the treatment and trust in their treating physician's treatment plan and/or prescription for the symptom relief are more likely to obtain relief. ([4 2])

Placebo responses are necessary for controlled clinical trials in which the patient is informed that a placebo may indeed be utilized. Physiologic responses to placebo can be pleasant or unpleasant to the patient. An unpleasant effect attributable to administration of a placebo is called a "nocebo response". A pleasant effect is called a "positive placebo response". It has been noted that, "a positive placebo response simply speaks to the strength of an individual's central control processes (i.e., mind) to recruit their descending inhibitory system to block pain. The trained osteopathic physician knows that pain relief occurs both in the mind and in the body." ([4]) The basis of the placebo effect in a therapeutic physician-patient relationship also involves good communication skills as well as listening to the patient. ([4, 11, 12])

To summarize, a placebo is a type of treatment, necessarily used in controlled clinical trials, that has no inherent physiological action yet is designed to mimic a therapy with a known active physiologic effect. Positive changes resulting from placebo administration would be due to expectations of success by the patient. Thus, the use of placebo effect is based on the patient's perception of the role of the placebo agent with symptom relief. The placebo response may be enhanced with a positive patient-physician relationship.

B. Addiction, substance **USE DISORDER**, ~~abuse and dependence,~~ tolerance, withdrawal, and pseudo-addiction.

Some physicians inappropriately justify using **A** placebo in pain management to avoid **GENERATING A SUBSTANCE USE DISORDER** ~~"addicting" the patient~~. Addiction, as defined by the American Academy of Pain Medicine,([13]) "is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving."

Substance **USE DISORDER** ~~abuse~~ is defined as **THE HARMFUL USE OF SUBSTANCES DESPITE NEGATIVE CONSEQUENCES**. ~~psychological and physical dependence on substances.~~ Some physicians are concerned that prescribing narcotics may lead to substance **USE DISORDER** ~~abuse~~ and therefore may attempt to use a placebo to assess whether the patient truly requires narcotics for pain relief. However, there is no scientific basis for using placebo in the assessment of the patient in pain who has or may have the potential for a substance **USE DISORDER** ~~abuse.~~ The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) ([14]), lists definitive criteria for diagnosis of psychological and physical dependence on substances. This text categorizes “Substance-Related Disorders” but does not utilize the term addiction; further, nowhere in the DSM-V is placebo administration utilized with criteria for diagnosing various forms of substance **USE DISORDERS.** ~~abuse.~~ Substance **USE DISORDER** ~~dependence~~ **ENCOMPASSES** ~~is defined as~~ a cluster of cognitive, behavioral, and physiological symptoms. The essential feature of a substance **USE DISORDER** ~~dependent individual~~ is continuous use of the substance despite significant substance-related problems, such as deleterious effects on occupation, relationships, health, and others.

Physicians may become uncomfortable with requests for increased dosages of pain medications, fearing that a patient is manifesting a substance-related disorder. A better understanding of the concepts of tolerance, physical dependence, physiological dependence withdrawal symptoms and pseudo-addiction, may help physicians understand and more effectively treat these patients.

Tolerance represents a markedly diminished effect that can occur with continued use of most medications; the degree depends upon the daily dose and length of use. The need for medication titration, either due to development of tolerance or to incomplete responsiveness, is a part of routine medical care. Tolerance occurs due to compensatory changes in receptors and/or increased clearance resulting from induction of various metabolic pathways. The problem of tolerance should therefore be anticipated as a possible outcome in prescription pain medications.

Withdrawal is defined by the DSM-V ([14]) as a maladaptive behavioral change having physiological and cognitive concomitants, which occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged use of the substance, frequently inappropriately. Examples of withdrawal include the onset of seizures or delirium tremens in a newly abstinent alcohol chemically dependent individual.

Pseudo-addiction is the term used to describe the behavior of a patient in pain who is receiving an insufficient amount and/or an inappropriate dosing frequency of administration of the prescribed pain medication. In an effort to obtain relief, the patient in pain would request more frequent and/or increased medication. Such “drug seeking behavior” has been deemed as “proof” of “addiction.” The reason for such requests is frequently that the patient is under-dosed, receiving too little of the medication and/or too long a delay between doses of the pain medication. In such instances, the patient receives inappropriate pain relief, which is not an appropriate criterion of a **SUBSTANCE USE DISORDER** ~~substance-abusing patient~~ according to the DSM-V. ([14])

126 II. Legal Considerations in the Use of Placebos in Pain Management
127 While there are no specific laws governing the use of placebos in any circumstance, there
128 is a considerable amount of legislation regarding a patient's right to pain management.
129 There are several state statutes that address this issue, some of which are based on the
130 Federation of State Medical Boards' Model Guidelines for the Use of Controlled
131 Substances for the Treatment of Pain.([15]) This document clarifies that legislative statutes
132 accepting these guidelines understand the ongoing increased scientific knowledge of pain
133 management, and thus have no need to modify legislation as the science of pain
134 management changes. This document does not mention placebo usage.
135
136 The American Bar Association (ABA) ([16]) adopted a resolution concerning the promotion of
137 pain management in all patients with chronic pain. This resolution states, "…that the
138 American Bar Association urges federal, state, and territorial governments to support fully
139 the rights of individuals suffering from pain to be informed of, choose, and receive effective
140 pain and symptom evaluation, management and ongoing monitoring as part of basic
141 medical care, even if such pain and symptom management may result in analgesic
142 tolerance, physical dependence or as an unintended consequence shorten the individual's
143 life." Placebo substitution for active pain medicine without informed consent on the part of
144 the patients clearly violates the nature and substance of the ABA's position. Additionally, in
145 two Supreme Court decisions regarding the right to assisted suicide, the court promoted
146 the right of individuals to appropriate palliative care and pain management. ([17, 18])
147
148 While there is little case law concerning tort or administrative findings against physicians
149 for inadequate pain management, this is likely to change in the near future. The main
150 barrier to malpractice claims for inadequate pain management is use of the customary
151 local standard to determine what constitutes ordinary care. The courts are steadily moving
152 away from this standard to a national standard which uses clinical guidelines as the
153 determinant of ordinary care. This is seen in the decision in the case of Nowatske v.
154 Oserloh, where the court stated, "should customary medical practice fail to keep pace with
155 development and advances in medical science, adherence to custom might constitute a
156 failure to exercise ordinary care…" ([19])
157
158 Guidelines developed by the Agency for Healthcare Policy and Research, now the Agency
159 for Healthcare Research and Quality ([1]), the American Pain Society, ([7]) the Healthcare
160 Facilities Accreditation Program ([20]) as well as the Joint Commission on Accreditation of
161 Healthcare Organizations ([21]) are good examples of sources the courts are using to
162 determine ordinary practice. These guidelines do not support the use of placebo in any
163 fashion except in approved research studies when the appropriate patient informed
164 consent has been obtained. Therefore, the physician thus cannot justify the use of placebo
165 for pain management by attempting to diagnose "addiction" or with support from any of the
166 above regulatory agencies. ([5])
167 Furthermore, under California's elder abuse statute, ([22]) a physician was successfully sued
168 by the deceased's family for inadequate pain management at the end of life. ([23])
169
170 III. Adverse Effects of Placebo Use
171

Pain is a universal experience and is subjective by nature. Despite the common colloquialism, “I feel your pain,” no individual can truly experience another’s pain. There are no laboratory tests or consistently reliable physical findings for assessment of pain. Patient self-report remains the gold standard for pain assessment. ([24]) Use of a placebo in place of an effective pain medication for attempting to determine whether the patient at end-of life is really in pain is under no circumstances appropriate.

There is a concern if a physician deceives the patient and substitutes a placebo treatment in the place of a known effective treatment without informing the patient. Deception has no place within the therapeutic relationship and is counter-productive. A physician may counsel a patient that “this treatment may be effective in treating your condition,” but evidence-based medicine cannot guarantee a treatment outcome.

In this era of informed consent, deception of the patient poses many problems, including erosion of the trust individuals and society as a whole have for physicians. There are methods of using placebos and the placebo effect that do not involve deceit, e.g., clinical trials or the use of placebo as one of the trial agents for neurolytic block. This one narrow exception uses the placebo trial as part of the treatment selection for neurolytic blockade, a highly specialized procedure performed by a few skilled pain management physicians with appropriate informed consent.

Substituting placebo for accepted forms of pain treatment is under-treatment of the condition. Under-treatment of pain, as detailed in the American Bar Association’s 2000 report, is an ongoing problem. ([25]) While there have been reports of placebo efficacy in pain management, placebo control of pain occurs in fewer patients and for shorter duration than active pain treatments. ([7, 26]) It has also been argued that the prescription of an ineffective placebo in place of effective pain medication can act as a “suicidogen,” whereby an individual in pain who is given inadequate medication for relief may be prompted to hasten his/her death. ([6]) In the clinical setting, substitution of a placebo for an active pain medication, even with the consent of the patient, is clinically suspect because better treatment alternatives exist and there are risks associated with the use of placebos. It is therefore inappropriate to substitute a placebo for a medication known to be effective in the treatment of a patient with the verified pain of a terminal illness.

Additionally, placebos are associated with side effects ([3]) and potentially precipitate hyperalgesia ([27]) or withdrawal in patients previously treated with pain medications.

IV. Summary

Exquisite management of end-of-life pain is a medical imperative. Use of a placebo in place of known effective pain medication for determining whether the patient is really in pain is under no circumstances appropriate. Use of placebos does not meet the accepted criteria to diagnose substance **USE DISORDER** ~~abuse,~~ commonly referred to by some physicians as “addiction.” There is no medical justification for the use of placebos to assess or treat pain at end of life.

The only appropriate use of a placebo is in approved clinical research with informed consent.

References:

1. Agency for Health Care Policy and Research. Management of Cancer Pain, Clinical Practice Guideline, Number 9, AHCPR Publication Number 94-0592. Sept10, 2002 <http://www.ahcpr.gov/gils/00000176.HTM
2. Barsky AJ et al . Nonspecific medication side effects and the nocebo phenomenon. JAMA. 2002 Feb 6; 287 (5):622-7.
3. Benedetti F, Amanzio M, Casadio C, Oliaro A, Maggi, G et al. Blockade of nocebo hyperalgesia by the cholecystokinin antagonist proglumide. International Association for the Study of Pain 1997 Jun; 71(2):135-40.
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5. Brody H. The lie that heals: the ethics of giving placebos. Annals of Internal Medicine. 1982 July 97(1):112-8.
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8. Emmanuel L et al . Foundations for Physicians on End-of-Life Care Curriculum. The EPEC Project, The Robert Wood Johnson Foundation. 1999. M4-4.
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15. Portenoy R.K. Contemporary Diagnosis and Management of Pain in Oncologic and AIDS Patients. Handbooks in Health Care Co., 1998.
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17. Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain. Fifth Edition. American Society of Pain. 2003. p 37-39.
18. "Proposed ABA Policy on Legal Obstacles To Effective Pain Management," American Bar Association 11 July 2000 http://www.abanet.org/aging/policyfinal.doc
19. Withdrawal Hyperalgesia after Acute Opioid Physical Dependence in Non-addict Humans: A Preliminary Study. Journal of Pain 4 (9):511-19 Nov 2003.
20. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Washington, DC, American Psychiatric Association, 1994.
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23. Sullivan M, Terman Gw, Peck B, Correll Dj, Rich B, Clark Wc, Latta K, Lebovits A, Gebhart G; American Pain Society Ethics Committee. Aps Position Statement On The Use Of Placebos In Pain Management. J Pain 2005 Apr 6(4):215-217.
24. Arnstein P, Broglio K, Wuhrman E, Kean M B. The use of Placebos In Pain Management. Pain Management Nursing 2011 Dec 12 (4): 225-229.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above (2004; 2009; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Referred)

Prior HOD action on similar or same topic:
H310-A/24 Referred to Bureau of Research and Public Health

FISCAL IMPACT: $0

ACTION TAKEN: __*Referred to Bureau of Osteopathic Public Health and Research*

DATE: _July 19, 2025_____________

SUBJECT: ~~MARIJUANA & THC – UNINTENTIONAL PEDIATRIC INGESTION PREVENTION~~ **PREVENTION OF PEDIATRIC CONSUMPTION OF CANNABIS, ITS DERIVATIVES, AND SYNTHETIC CANNABINOIDS**

SUBMITTED BY: Missouri Association of Osteopathic Physicians and Surgeons

REFERRED TO: Committee on Professional Affairs

WHEREAS, in 2025 thirty-nine states, three territories and the District of Columbia allow the medical use of cannabis products; and twenty-four states, three territories and the District of Columbia allow or regulate cannabis for non-medical adult (recreational) use[1], and

WHEREAS, there had been a consistent increase in pediatric edible cannabis exposures during the previous five years, with the most common site for exposure being residential settings (97.1%) and most of those exposures occurring in the patient's own residence (90.7%)[2], and

WHEREAS, since cannabis is illegal at the federal level, the Poison Prevention Packaging Act requirements are not binding, and states are responsible for regulating labeling and packaging of cannabis products[3], and

WHEREAS, the American College of Medical Toxicology has published guidelines for packaging of cannabis to prevent pediatric ~~ingestion~~ **CONSUMPTION** and poisoning which include 1) requiring child-resistant packaging consistent with the Poison Prevention Packaging Act, and 2) prohibition of labeling and advertising that might appeal to children[4], therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports ~~state~~ legislation and regulation that ensures 1) ~~marijuana and tetrahydrocannabinol (THC)~~ **CANNABIS, ITS DERIVATIVES, AND SYNTHETIC CANNABINOIDS** containing products are not manufactured, labeled, or marketed in a manner that could potentially be appealing to minors, and 2) they are packaged in a manner to prevent pediatric ~~ingestion~~ **CONSUMPTION**.

References:

[1]National Council of State Legislatures. (2020). www.ncsl.org/civil-and-criminal-justice/cannabis-overview.

[2]Shenouda, J., et al. (2023) Pediatric Edible Cannabis Exposures and Acute Toxicity: 2017 – 2021. *Pediatrics*. 151(2), February 2023.

[3]Lisi, D.M., Pharm D. (2022). Cannabis Edibles and Pediatric Toxicity Risk. *U.S. Pharmacist.* 47(8)HS-2-11.

[4]Amirshahi, M.M., Moss, M.J., Smith, S.W. *et al.* ACMT Position Statement: Addressing Pediatric Cannabis Exposure. *J. Med. Toxicol.* **15**, 212–214 (2019). https://doi.org/10.1007/s13181-019-00708-z.

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: ______July 19, 2025_______________

SUBJECT: ~~MARIJUANA~~ **CANNABIS** CESSATION COUNSELING REIMBURSEMENT

SUBMITTED BY: American College of Osteopathic Family Physicians (ACOFP)

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, marijuana is the second most commonly used mind-altering substance in
2 the United States, widely legalized for medicinal *and* recreational use [(1)]; and

3 WHEREAS, 19 million people met the criteria for marijuana use disorder in 2022 [(1)]; and

4 WHEREAS, the National Institute on Drug Abuse identifies marijuana as an addictive
5 drug and marijuana products have been shown to cause dependence, including
6 the potential for withdrawal effects [(1)]; and

7 WHEREAS, the Centers for Medicare and Medicaid Services (CMS) will cover 2 tobacco
8 cessation attempts per year, with each attempt including a maximum of four
9 intermediate or intensive sessions, with the total annual benefit covering up to 8
10 sessions in a 12-month period with the codes 99406 and 99407 [(2)]; and

11 WHEREAS, Medicare covers these services in both inpatient and outpatient settings and
12 now waves the deductible or copayment for patients, with net zero cost to
13 patients [(2)]; and

14 WHEREAS, tobacco cessation has significant health risk reduction benefits warranting
15 the incentive for providers to counsel on cessation; and

16 WHEREAS, marijuana, although not yet as heavily researched as tobacco, has still
17 been shown to also have long term negative health consequences including
18 impacts on lung health, mental health (psychosis, schizophrenia, depression),
19 cardiovascular effects (stroke, heart attack, arrhythmia), gastrointestinal issues
20 (cannabinoid hyperemesis syndrome, PUD), concentration, memory, fetal
21 complications in pregnancy, and cancer risk (throat, head and neck) [(3)] now,
22 therefore be it

23 RESOLVED, that the American Osteopathic Association (AOA) encourages further
24 research on ~~marijuana~~ **CANNABIS AND ITS DERIVATIVES** and its potential
25 health benefits and risks; and, be it further

26 RESOLVED, that the AOA advocate for legislation requiring insurance companies to
27 reimburse ~~providers~~ **PHYSICIANS AND NON-PHYSICIAN CLINICIANS** for
28 ~~marijuana~~ **CANNABIS** cessation counseling; and, be it further

29 RESOLVED, that the AOA advocate that CMS reimburse physicians for ~~marijuana~~
30 **CANNABIS** cessation counseling in a similar way to tobacco cessation
31 counseling.

References:

1. Sharp, Amelia. *How to Quit Smoking Marijuana.* Nov. 15, 2024. American Addiction Centers. https://americanaddictioncenters.org/marijuana-rehab/quit-marijuana.
2. *Smoking & Tobacco Use Cessation Counseling.* Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=130#:~:text=Minimal%20counseling%20is%20already%20covered,in%20a%2012%20month%20period.
3. *Cannabis (Marijuana).* Sept 2024. National Institute of Drug Abuse. https://nida.nih.gov/research-topics/cannabis-marijuana#short-term-health-cannabis.

Background Information: Provided by AOA Staff
Current AOA Policy:
H424-A/21 Medical Cannabis – Research on
H428-A/22 Recreational Cannabis Use by Physicians, Students and Patients – White Paper

No direct duplicate on payment, but AOA supports payment for substance use disorder counseling:
H608-A/20 Health Plan Coverage of Tobacco Cessation Treatment
H325-A/23 Physician Payment for Electronic Advice, Counseling and Treatment Plans

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ________July 19, 2025____________

SUBJECT: RURAL HOSPITAL FUNDING

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, 60 million people in the United States (20% of the population) live in rural areas [1]; and

WHEREAS, Section 1820 of the Social Security Act established Medicare Rural Hospital Flexibility Programs (MRHFPs) that allow individual states to designate certain facilities as critical access hospitals (CAHs) [2]; and

WHEREAS, CAHs provide vital healthcare services to patients in rural areas; and

WHEREAS, over the past two decades, nearly 200 rural hospitals have closed [3]; and

WHEREAS, more than 700 rural hospitals– one-third of all rural hospitals in the country– are at risk of closing because of the serious financial problems they are experiencing [3]; and

WHEREAS, the Medicare and Medicaid programs are major funding sources for services provided by CAHs, and

WHEREAS, a significant number of osteopathic physicians practice in rural areas including in CAHs [4]; and

WHEREAS, Congress **HAS PASSED LEGISLATION THAT AMOUNTS** ~~is considering proposals that would amount~~ to the largest Medicaid cut in the program's history [~~4~~**5**]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA), ~~through its Washington office~~ advocate for adequate funding for critical access hospitals.

References:

1. https://www.census.gov/newsroom/press-releases/2022/urban-rural-populations.html accessed May 1, 2025
2. https://www.cms.gov/files/document/mln006400-information-critical-access-hospitals.pdf accessed May 1, 2025
3. https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf accessed May 1, 2025
4. https://osteopathic.org/index.php?aam-media=/wp-content/uploads/2024-OMP-Report.pdf accessed May 1, 2025

5. https://www.congress.gov/bill/119th-congress/house-bill/1/text

Background Information: Provided by AOA Staff
Current AOA Policy:
H439-A/24 Physician Supply in Rural, Underserved United States – Recommendations for Improving
H314-A/23 Rural Healthcare Payment Equity
H201-A/24 Health Care Shortage in Rural America
H216-A/21 Rural Healthcare Provided by Current GME Programs – Preservation of

H439-A/24 is the only policy that mentions "critical access hospitals" directly, but all policies listed above directs the AOA to advocate for rural funding.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _________July 19, 2025___________

SUBJECT: PHARMACY BENEFIT MANAGERS (PBMS)

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Professional Affairs

WHEREAS, nearly one in three retail pharmacies have closed since 2010[1]; and

WHEREAS, rural, black, and Latin X communities have been disproportionately been impacted by these closures worsening pre-existing health disparities [1]; and

WHEREAS, independent pharmacies have been twice as likely to close as chain pharmacy stores [1]; and

WHEREAS, Pharmacy Benefits Managers (PBMs) now control nearly 90% of all pharmacy benefits with just three companies being responsible for 80% of those prescription drug claims [2]; and

WHEREAS, PBMs not only manage pharmacy benefits but also own major pharmacy chains or mail order pharmacies or are owned by major insurers [3]; and

WHEREAS, these relationships have led PBMs to develop preferred pharmacy networks that exclude or reduce payments to independent pharmacies [3]; and

WHEREAS, these practices have led to the creation of pharmacy deserts, increased consumer costs, and created restrictive formularies, thereby reducing access to healthcare goods and services; now, therefore be it

~~RESOLVED, that the American Osteopathic Association (AOA) supports legislation/regulation which addresses the healthcare access challenges created by current Pharmacy Benefit Managers (PBMs); and, be it further~~

~~RESOLVED~~, **WHEREAS**, that possible solutions include but are not limited to:

1. Increased PBM pricing transparency
2. Prohibiting PBMs from providing preferred payments to pharmacies owned by the PBM
3. Prohibiting PBMs from requiring use of pharmacies owned by the PBM
4. Passing the full amount of manufacturer rebates on to ~~insurers~~ **PATIENTS**
5. Prohibiting spread pricing

28 6. Encouraging anti-trust investigations into PBMs

29 **RESOLVED, THAT THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA)**
30 **SUPPORTS LEGISLATION OR REGULATION WHICH ADDRESSES THE**
31 **HEALTHCARE ACCESS CHALLENGES CREATED BY CURRENT**
32 **PHARMACY BENEFIT MANAGERS (PBMS**).

References:
1. Guadamuz, etal., More US Pharmacies Closed Than Opened In 2018–21; Independent Pharmacies, Those In Black, Latinx Communities Most At Risk, Journal of Health Affairs, December 2024, https://doi.org/10.1377/hlthaff.2024.00192

2. https://www.drugchannels.net/2024/04/the-top-pharmacy-benefit-managers-of.html accessed April 11, 2025

3. https://www.americanprogress.org/article/5-things-to-know-about-pharmacy-benefit-managers accessed April 11, 2025

Background Information: Provided by AOA Staff
Current AOA Policy:
H334-A/24 Pharmacy Benefit Managers-Increased Regulation of – White Paper

Prior HOD action on similar or same topic:
H334-A/24 Pharmacy Benefit Managers-Increased Regulation of – White Paper

FISCAL IMPACT: $0

ACTION TAKEN: *Referred to Iowa Osteopathic Medical Association*

DATE: July 19, 2025

SUBJECT: SUPPORT FOR METHODS TO INCREASE THE COMPENSATION FOR PEDIATRICIANS TO ADDRESS FUTURE WORKFORCE CHALLENGES

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, pediatrics is a critical specialty in the American Healthcare system, providing
2 essential care to infants, children, and adolescents and contributing to the long-term
3 health of the population [1]; and
4
5 WHEREAS, the number of graduating medical students matching into pediatric residency
6 programs has declined in recent years, leading to concerns about the adequacy of the
7 future pediatric workforce [2]; and
8
9 WHEREAS, pediatricians face unique financial challenges, including lower average
10 compensation compared to many other medical specialties, despite the high demands
11 of their work and the complex care required by pediatric patients [2,3]; and
12
13 WHEREAS, pediatricians often care for a disproportionately high percentage of Medicaid
14 populations, which are subject to lower reimbursement rates and increased
15 administrative burdens, further impacting their financial viability [2,3]; and
16
17 WHEREAS, addressing the compensation disparities faced by pediatricians is necessary
18 to increase the attractiveness of the specialty to graduating medical students who face
19 a heavy medical school debt load, to ensure adequate access to pediatric care
20 nationwide [4]; and, now therefore be it:
21
22 RESOLVED, that the American Osteopathic Association (AOA) advocate for the
23 exploration and implementation of creative methods to increase the compensation of
24 pediatricians, including but not limited to:

25–26 ~~• Advocacy for increased Medicaid and Medicare reimbursement rates for pediatric services~~

27–29 ~~• Development of loan repayment programs, scholarships, or financial incentives targeted specifically at medical students and residents pursuing primary care pediatrics~~

30–31 ~~• Establishing public and private grants or subsidies to support pediatric practices in underserved or high-need areas~~

32–33 ~~• Promoting value-based care models that reward pediatricians for improving health outcomes in vulnerable populations, and be it further~~

34

35 RESOLVED, that the AOA ~~advocate for~~ **SUPPORT** collaboration with federal and state
36 policymakers, healthcare organizations, and medical education stakeholders to
37 advocate for policy reforms that address financial barriers to entering the pediatric
38 specialty; and be it further
39
40 RESOLVED, that the AOA ~~advocate for~~ **SUPPORT** research into innovative payment
41 models and compensation structures for pediatricians to ensure long-term sustainability
42 of the pediatric workforce for the future~~., and be it further~~
43
44 ~~RESOLVED, that a copy of this resolution be submitted to the AOA for consideration at the~~
45 ~~2025 AOA House of Delegates~~.

References:

1) Pediatricians. 27 Jan 2025. Cleveland Clinic. Doi: https://my.clevelandclinic.org/health/articles/21716-what-is-a-pediatrician
2) Carroll, A. Why Doctors aren't going into pediatrics. New York Times. 1, July, 2024. Doi: https://www.nytimes.com/2024/07/01/opinion/pediatrician-shortage.html
3) Rascoe, A. Fewer Doctors are going into Pediatrics: That's leaving a huge gap in hospitals. NPR. 14, April 2024. Doi: https://www.npr.org/2024/04/14/1244683914/fewer-doctors-are-going-into-pediatrics-thats-leaving-a-huge-gap-in-hospitals
4) Permar, S and RJ Vinci. A nation with too few pediatricians could see health care costs soar. STAT: Reporting from the frontiers of health and medicine. 2 April 2024. Doi: https://www.statnews.com/2024/04/02/too-few-pediatricians-health-care-costs/%6

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

Overarching Policies but not specific to pediatrics:

H612-A/20 Medicaid Payment
H317-A/20 Physician Incentives to Underserved Areas
H341-A/21 Appropriate Payment Mechanisms for Physician-Led Team-Based Health Care
H321-A/22 Equity in Medicare & Medicaid Payments

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: DEFINITION OF OSTEOPATHIC PHYSICIAN

SUBMITTED BY: Osteopathic Physicians and Surgeons of California

REFERRED TO: Committee on Professional Affairs

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1 WHEREAS, osteopathic medicine has struggled to define itself in a way that
2 represents all U.S. trained osteopathic physicians, regardless of specialty or
3 use of Osteopathic Manipulative Treatment (OMT); and

4 WHEREAS, American Osteopathic Association (AOA) policy H317/A23 defines
5 osteopathic medicine as follows:

6 *The American Osteopathic Association (AOA) defines osteopathic medicine*
7 *as a complete system of medical care with a philosophy that combines the*
8 *needs of the patient with the current practice of medicine, surgery and*
9 *obstetrics; that emphasizes the concept of body unity, the interrelationship*
10 *between structure and function; and that has an appreciation of the body's*
11 *ability to heal itself*; and

12 WHEREAS, there is a need for the profession to align around a common,
13 contemporary definition that enables research, grant funding, physician
14 reimbursement, and public education and marketing; and

15 WHEREAS, adoption of a unified, modern definition of a U.S. trained osteopathic
16 physician will strengthen internal cohesion and promote clearer external
17 understanding and communication of the role and philosophy of the
18 osteopathic physician; and

19 WHEREAS, the upcoming *Educational Council on Osteopathic Principles (ECOP)*
20 *Glossary of Osteopathic Terminology* includes the following definition:

21 *Doctor of Osteopathic Medicine (DO), United States: an osteopathic*
22 *physician who has graduated from a COCA-accredited institution and is a*
23 *fully qualified physician, educated within the context of a distinct patient-*
24 *centered, health-oriented philosophy, trained to combine specialized*
25 *diagnostic and therapeutic hands-on skills (Osteopathic Manipulative*
26 *Treatment) with the latest advances in the science and practice of medicine*
27 *to offer comprehensive healthcare to patients*; now, therefore be it

28 RESOLVED, that the American Osteopathic Association (AOA) adopt the
29 Educational Council on Osteopathic Principles *(*ECOP) definition of "Doctor
30 of Osteopathic Medicine, United States" for profession-wide use; and be it
31 further

32 RESOLVED, that the AOA encourage all affiliated entities to utilize this definition in
33 all activities involving the definition and representation of a U.S. trained
34 osteopathic physician.

Background Information: Provided by AOA Staff
Current AOA Policy:
H317-A/23-Osteopathic Medicine Definition
H626-A/24-Osteopathic Terminology - Glossary of
H340-A/24-Clarification on the Terms "Osteopathy, and "Osteopath" in the United States

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted________

DATE: _____July 19, 2025_____________

SUBJECT: AOA PROGRAM PARTICIPANTS AND AWARDS CRITERIA POLICY

SUBMITTED BY: AOA Board of Trustees

REFERRED TO: Committee on Professional Affairs

WHEREAS, in 2024 the AOA President constructed an AOA Program and Award Recipients Workgroup; and

WHEREAS, the charge of the workgroup was to confirm guidelines for participants and recipients for the following AOA programs: AOA Awards Recipients; AOA Program Participants (i.e., Leadership Academy, TIPS Program); BEL Scholarship Recipients; Bureaus, Committees, and Councils Appointments; Task Force and Liaison Appointments; Research Grant Recipients; A.T. Still Lecturers; Presidential Citation Recipients; Speakers and Presenters During AOA Events; and Media Recognition Outlets (i.e., The DO, DOs to Know); and

WHEREAS, the workgroup also was charged to determine if recipients and participants who are eligible for AOA membership be required to maintain current AOA membership and if recipients and participants who are DOs eligible for board certification maintain current AOA board certification status for each of the programs; and

WHEREAS, the AOA's Constitution and Bylaws contain requirements for AOA membership but there are no requirements for AOA board certification; and

WHEREAS, the workgroup completed a report that was reviewed and approved by the AOA Board of Trustees in July 2024; and now, therefore be it

RESOLVED, that the AOA House of Delegates accept the AOA Program Participants and Awards Criteria Policy provided with this resolution~~; and be it further~~

~~RESOLVED, that the AOA Board of Trustees will establish a task force that will further study AOA board certification as a requirement for specific AOA positions~~.

Background Information: Provided by AOA Staff
Current AOA Policy: Approved by the AOA Board of Trustees July 2024.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended__

DATE: ___July 19, 2025________________

AOA Program Participants and Awards Criteria Policy

Program	**Program Description / Criteria**	**AOA Membership**	**AOA Board Cert**
Bureaus, Committees, and Council	** Except where positions are designated for public members (i.e., non-physicians serving on a bureau or committee who are intended to represent and speak for the interests of the public and consumers of osteopathic medical services), membership in both the AOA and a divisional society shall be a requisite for qualification for service on a bureau, council, or committee of the Association. (AOA Bylaws, Article IX) – AOA board certification is preferred.	Required (with exceptions)	Preferred (with exceptions)
BEL DO Day Scholarship Program	Scholarships to attend DO Day are awarded to osteopathic physicians in training and new physicians in practice who want to become more involved in medical advocacy. AOA membership is a requirement to receive this scholarship. AOA board certification is preferred.	Required	Preferred
BEL OMED Scholarship Program	Osteopathic residents, fellows, and new physicians in practice who are enrolled in an ACGME-accredited postdoctoral training program (if you are a resident/fellow) within five years of completing postdoctoral training (if you are a new physician in practice), and a first-time OMED attendee. AOA membership is a requirement to receive this scholarship. AOA board certification is preferred.	Required	Preferred (with exceptions) Exceptions will include postdoctoral trainees
Leadership Academy Program	This academy is designed for osteopathic medical students, residents, fellows, and new physicians in practice who want to enhance their leadership skills. Candidates preferably have some leadership experience within the profession prior to participating in the program. AOA membership is a requirement to receive this scholarship. AOA board certification is preferred.	Required	Preferred (with exceptions) Exceptions will include postdoctoral trainees and osteopathic medical students

Program	Program Description / Criteria	AOA Membership	AOA Board Cert
Liaison Appointments	Recommendations for appointments are submitted to the President, President-Elect, and CEO for review and approval. The Board of Trustees will approve all appointments. AOA membership is required. AOA board certification is preferred. Exceptions will be made for those who represent other fields of public service.	Required (with exceptions)	Preferred (with exceptions)
Task Force Appointments	Recommendations for appointments are submitted to the President, President-Elect, and CEO for review and approval. The Board of Trustees will approve all appointments. AOA membership is required. AOA board certification is preferred. Exceptions will be made for those who represent other fields of public service.	Required (with exceptions)	Preferred (with exceptions)
Training In Public Studies (TIPS) Program	The TIPS program is open to all osteopathic physicians who are in an active AOA- or ACGME-accredited residency or fellowship training program to apply. In addition, our letter of acceptance to the program requires fellows to become members of the AOA at the resident physicians and fellows level, at minimum. AOA board certification is not required.	Required	Not Required

Awards and Recognition

Program	Program Description / Criteria	AOA Membership	AOA Board Cert
Awards: Advocacy Awards	AOA advocacy awards are intended to recognize excellence in public policy advocacy and support for the osteopathic profession through various media/communication platforms. Award categories will include individual AOA members (including students and residents), osteopathic affiliates, media advocates, and members of Congress. Except for categories recognizing public service individuals, recipients are required to be AOA members. AOA board certification is not required. *The Bureau on Federal Health Programs recommends final recipients to the BOT.*	Required (with exceptions)	Not Required

Program	**Program Description / Criteria**	**AOA Membership**	**AOA Board Cert**
Awards: Bob E. Jones CAE Award	The Bob E. Jones, CAE Award recognizes outstanding executive directors/CEOs who continually contribute to the AOA and the osteopathic profession. All executive directors/CEOs from state affiliates, specialty affiliates, and osteopathic stakeholder organizations are eligible for nomination for the award. Nominations may be self-nominated, peer-nominated from other AOA affiliate EDs/CEOs, or from national AOA or affiliate volunteer leadership. Recipient(s) will be encouraged to become AOA Associate members. AOA board certification is not required. *The Bureau of Affiliate Relations recommends final recipients to the BOT.*	Preferred	Not Required
Awards: Distinguished Service Award	The Distinguished Service Award is the American Osteopathic Association's (AOA) highest honor. It is awarded annually to deserving physicians or lay individuals for outstanding accomplishments in advancing the science and art of osteopathic medicine, education, philanthropy, or other fields of public service. Preferential consideration will be given to those individuals whose service has been to or through the osteopathic medical profession. AOA board certification is not required. This award recognizes contributions to the overall profession rather than regional or local efforts. *The Committee on Awards recommends final recipients to the BOT.*	Preferred (with exceptions)	Not Required
Awards: DEI Award	The DEI Award will be presented to one individual and one organization that has proven exemplary leadership and commitment to promoting and advancing DEI initiatives in the osteopathic community. AOA membership is preferred with exception. AOA board certification is preferred. *The Committee on Awards recommends final recipients to the BOT.*	Preferred (with exceptions)	Preferred
Awards: *Journal of Osteopathic Medicine (JOM)* Awards	Each year, the *Journal of Osteopathic Medicine* will recognize an article with significant contributions to Social Determinants of Health Research, Innovations Research, Health Policy Research, Quality Improvement in Education Research, Junior Faculty / Young Investigators Research, and Clinical Research. AOA board certification is preferred. *The JOM Editorial Board recommends final recipients to the BOT.*	Preferred	Preferred

Program	Program Description / Criteria	AOA Membership	AOA Board Cert
Awards: Mentor of the Year	The AOA Mentor of the Year Award was developed to honor DOs who help shape the future of the osteopathic profession through their involvement with osteopathic medical students and new physicians in practice. Students, DOs, AOA affiliates, or any other member of the osteopathic professional family are welcome to submit nominations. The nominee must be a member, in good standing, of the AOA. AOA board certification is preferred with exception. *The Bureau of Emerging Leaders recommends final recipients to the BOT.*	Required	Preferred (with exceptions)
Awards: Outstanding Affiliate Awards	This award recognizes the tremendous contributions that affiliates make to the success of the osteopathic profession. All state and specialty college affiliates are eligible for nomination for the Outstanding Affiliate Awards. Affiliates can self-nominate or be nominated by others for this award. Previous award recipients are ineligible for Outstanding Affiliate Award nomination until three years have elapsed. *The Bureau of Affiliate Relations recommends final recipients to the BOT.*	Not Required	Not Required
Awards: Media Recognition Outlets	Osteopathic physicians recognized in this arena are encouraged to become AOA members. AOA board certification is preferred if the individual is eligible for board certification and if AOA board certification is available. Exceptions will be made for those who represent other fields of public service.	Preferred (with exceptions)	Preferred (with exceptions)
Awards: Presidential Citations	Recipients are osteopathic medical profession leaders or groups who are honored by the current AOA President for their accomplishments and contributions to the osteopathic profession. The president is given full latitude on who will receive this award.	Not Required	Not Required

Additional Opportunities

Program	Program Description / Criteria	AOA Membership	AOA Board Cert
A.T. Still Memorial Lecturer	An individual is selected and formally invited to deliver the Andrew Taylor Still Memorial address during the House of Delegates meeting annually. AOA membership is preferred. AOA board certification is preferred,	Preferred	Preferred (with exceptions)
Journal of Osteopathic Medicine (JOM) Editorial Board	AOA membership is required with exceptions. AOA board certification is preferred. This process is currently under review. The final criteria will be updated upon approval from the AOA Board of Trustees.	Required (with exceptions)	Preferred (with exceptions)

Program	Program Description / Criteria	AOA Membership	AOA Board Cert
Research Grant Recipients	**Physicians and PhD Researchers**: Osteopathic Physician (DO); or MD, PhD, or other individuals holding an equivalent doctoral degree (applicants not affiliated with an osteopathic institution or osteopathic recognized programs must have a DO as key personnel on the Research Team). **New Investigators**: Osteopathic Physician (DO); or MD, PhD or other individuals holding an equivalent doctoral degree (applicants not affiliated with an osteopathic institution or osteopathic recognized programs must have a DO as key personnel on the Research Team). Must have completed their terminal research degree (e.g., PhD or equivalent doctoral degree) or post-graduate clinical training (e.g., residency, fellowship), whichever date is later, within the past 10 years of the date of the expected award. **Osteopathic Medical Students**: Applicants must be an osteopathic medical student fulfilling his/her coursework requirements at an AOA accredited College of Osteopathic Medicine at the time of the award. Must have a Preceptor/Mentor with qualifying criteria. Grant recipients are encouraged to become AOA members. AOA board certification is preferred.	Preferred	Preferred (with exceptions)
Speakers and Presenters During AOA Events (Non-CME Events)	Osteopathic physicians speaking and presenting at AOA events are encouraged to become members. An exception is made for professional speakers who speak for the interests of the public. AOA board certification is preferred.	Preferred	Preferred (with exceptions)
"The DO" Editorial Board	Interested parties submit information through the communication and marketing application process. All editorial advisory board members are to be members of the AOA. *The DO* Editor and communications staff review the applications and provide recommendations to the CEO and President. The CEO and President review and approve the recommendations to be provided to the Board. AOA board certification is preferred.	Required	Preferred (with exceptions)

AMERICAN OSTEOPATHIC ASSOCIATION

400 Series Public Affairs Resolutions

Actions

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105th ANNUAL AOA HOUSE OF DELEGATES MEETING
2025 RESOLUTION ROSTER (400 SERIES)
As of 07-19-25

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
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	Reference Committee	Action
H-400	Protection of Safe Water Supply (SR-Source-H405-A/20)	BFHP	Public Affairs	Adopted
H-401	Aircraft Emergency Medical Supplies (SR-Source-H411-A/20)	BFHP	Public Affairs	Referred to BFHP
H-402	Firearms and Non-Powdered Guns – Education for Users (SR-Source-H418-A/20)	BFHP	Public Affairs	Adopted as Amended
H-403	Drugs, Curbing Counterfeit (SR-Source-H426-A/20)	BFHP	Public Affairs	Adopted
H-404	Continued Support of Combating Bio-Terrorism Activities (SR-Source-H432-A/20)	BFHP	Public Affairs	Adopted
H-405	National Institutes of Health Grants (SR-Source-H437-A/20)	BFHP	Public Affairs	Adopted as Amended
H-406	Firearm Violence (SR-Source-H442-A/20)	BFHP	Public Affairs	Adopted as Amended
H-407	Background Checks and Firearms Safety Training as a Condition of Firearms Purchase (SR-Source-H446-A/20)	BFHP	Public Affairs	Adopted
H-408	Epidemic Terrorist Attack Victims, Government Responsibility Of Health Care (SR-Source-H453-A/20)	BFHP	Public Affairs	Adopted
H-409	Silver Alert System (SR-Source-H436-A/20)	BFHP	Public Affairs	Sunset
H-410	Public Education Regarding the Importance and Safety of Vaccines for Infants, Children, and Adults (SR-Source-H402-A/20)	BORPH	Public Affairs	Referred to BORPH
H-411	Support for the Advisory Committee on Immunization Practices (ACIP) Recommendations (SR-Source-H403-A/20)	BORPH	Public Affairs	Referred to BORPH
H-412	Antibiotic Stewardship (SR-Source-H406-A/20)	BORPH	Public Affairs	Adopted as Amended
H-413	Vaccines for Children Program (SR-Source-H407-A/20)	BORPH	Public Affairs	Referred to BORPH

105th ANNUAL AOA HOUSE OF DELEGATES MEETING
2025 RESOLUTION ROSTER (400 SERIES)
As of 07-19-25

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-414	Intrauterine Fetal Demise Awareness (SR-Source-H409-A/20)	BORPH	Public Affairs	Adopted
H-415	Animals in Medical Research (SR-Source-H412-A/20)	BORPH	Public Affairs	Adopted
H-416	Cancer (SR-Source-H413-A/20)	BORPH	Public Affairs	Adopted as Amended
H-417	Cardiopulmonary Resuscitation, Training (SR-Source-H414-A/20)	BORPH	Public Affairs	Adopted as Amended
H-418	Children's Safety Seats (SR-Source-H415-A/20)	BORPH	Public Affairs	Sunset
H-419	Environmental Responsibility--Waste Materials (SR-Source-H417-A/20)	BORPH	Public Affairs	Adopted
H-420	Genetic Manipulation of Food Products – Consumers Right to Know (SR-Source-H419-A/20)	BORPH	Public Affairs	Adopted
H-421	Condom Usage – Health Education (SR-Source-H420-A/20)	BORPH	Public Affairs	Adopted
H-422	Support of Literacy Programs (SR-Source-H421-A/20)	BORPH	Public Affairs	Adopted
H-423	Healthy Family, Support of (SR-Source-H424-A/20)	BORPH	Public Affairs	Adopted as Amended
H-424	Immunization of 9 to ~~26~~ **45** Year Old Male and Females with Human Papilloma Virus Vaccine (SR-Source-H425-A/20)	BORPH	Public Affairs	Adopted as Amended
H-425	Sleep Disorders - Promoting the Understanding and Prevention of (SR-Source-H427-A/20)	BORPH	Public Affairs	Adopted
H-426	Minority Health Disparities (SR-Source-H428-A/20)	BORPH	Public Affairs	Referred to BORPH
H-427	Infant Walker (Mobile) – Ban on the Manufacture, Sale and Use of (SR-Source-H429-A/20)	BORPH	Public Affairs	Adopted
H-428	Develop In-Vitro Fertilization Standards of Care (SR-Source-H430-A/20)	BORPH	Public Affairs	Not Adopted
H-429	Childhood Obesity – Worsening Epidemic in the American Society (SR-Source-H433-A/20)	BORPH	Public Affairs	Adopted
H-430	Texting While Driving (SR-Source-H435-A/20)	BORPH	Public Affairs	Adopted

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Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-431	Interference in the Physician-Patient Relationship by Personal Injury Attorneys and Insurance Carrier Agents (SR-Source-H400-A/20)	BORPH	Public Affairs	Adopted as Amended
H-432	Screening for Breast Cancer (SR-Source-H438-A/20)	BORPH	Public Affairs	Adopted
H-433	Gender Identity Non-Discrimination (SR-Source-H439-A/20)	BORPH	Public Affairs	Adopted as Amended
H-434	Traumatic Brain Injury Awareness (SR-Source-H440-A/20)	BORPH	Public Affairs	Adopted as Amended
H-435	Support for Family Caregivers (SR-Source-H441-A/20)	BORPH	Public Affairs	Adopted as Amended
H-436	Adopting and Promoting Non-Stigmatizing Language for Substance Use Disorders (SR-Source-H444-A/20)	BORPH	Public Affairs	Adopted
H-437	AOA Response to Novel Public Health Threats (SR-Source-H445-A/20)	BORPH	Public Affairs	Adopted as Amended
H-438	Homeless Support (SR-Source-H449-A/20)	BORPH	Public Affairs	Adopted as Amended
H-439	Breastfeeding While on Medication Assisted Treatment (MAT) (SR-Source-H452-A/20)	BORPH	Public Affairs	Adopted as Amended
H-440	Minorities, Underrepresented (URM) – Increasing Numbers of Applicants (SR-Source-H454-A/20)	BORPH	Public Affairs	Adopted as Amended
H-441	Regulation of E-Cigarettes and Nicotine Vaping (SR-Source-H455-A/20)	BORPH	Public Affairs	Adopted as Amended
H-442	Seat Belt Laws – Primary Enforcement (SR-Source-H408-A/20)	CSHA	Public Affairs	Adopted
H-443	Death - Right to Die (SR-Source-H416-A/20)	CSHA	Public Affairs	Adopted
H-444	Tanning Devices (SR-Source-H422-A/20)	CSHA	Public Affairs	Adopted as Amended
H-445	Tobacco Settlement Funds (SR-Source-H423-A/20)	CSHA	Public Affairs	Adopted

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2025 RESOLUTION ROSTER (400 SERIES)
As of 07-19-25

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-446	Vaccination Rates – Daycare Notification to Parents (SR-Source-H404-A/20)	CSHA	Public Affairs	Adopted
H-447	Protecting Patients with Private Insurance from Balance Billing (SR-Source H426-A/19; Referred H402-A/24)	BFHP	Public Affairs	Adopted
H-448	Raw Milk-Health Risks (SR-Source H416-A/19; Referred H413-A/24)	BORPH	Public Affairs	Adopted as Amended
H-449	Recognizing Breast Implant Illness (BII) (Source-Referred H434-A/24)	BORPH	Public Affairs	Adopted as Amended
H-450	Reaffirming Commitment to Evidence-Based Protection Against Vaccine-Preventable Illnesses	ACOP	Public Affairs	Adopted as Amended
H-451	Continued Support of Access to and Research on National Newborn Metabolic Screening Protocols	ACOP	Public Affairs	Adopted as Amended
H-452	Equitable Use and Coverage of Anti-Obesity Incretin Mimetic Medications	BEL	Public Affairs	Adopted as Amended
H-453	Advocate for Access to Overweight and Obesity Care	OOA (Ohio)	Public Affairs	Adopted as Amended
H-454	Against the Use of Food Dyes and Preservatives	OOA (Ohio)	Public Affairs	Adopted as Amended
H-455	Recognizing Period Poverty as a Policy Concern	SOMA	Public Affairs	Adopted as Amended
H-456	Sharing Centralized Resources on State-Specific Reproductive Health Policies	SOMA	Public Affairs	Referred to Finance
H-457	Family Planning and Fertility Preservation Resources for Medical Trainees	SOMA	Public Affairs	Adopted as Amended
H-458	Retail Medical Clinics in Facilities Selling Tobacco, Nicotine or Vaping Products	BORPH	Public Affairs	Not Adopted

SUBJECT: PROTECTION OF SAFE WATER SUPPLY - SOURCE: H405-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) encourages the oil industry and the
8 Environmental Protection Agency (EPA) to seek out new technologies for safer
9 disposal of waste well water and the protection of our water supply.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ______Adopted_____

DATE: _______July 19, 2025________

SUBJECT: AIRCRAFT EMERGENCY MEDICAL SUPPLIES
- SOURCE: H411-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports the concept that airlines,
8 under the control of the Federal Aviation Administration, maintain a policy for
9 adequately equipping commercial aircraft of greater than 19 seats with at least
10 minimal diagnostic and emergency medical supplies and supports legislation and
11 regulation that any physician providing emergency service while on board aircraft be
12 immune from any liability or legal action.

Background Information: Provided by AOA Staff
Current AOA Policy: 1984; 1989 Reaffirmed as Amended; 1995 Reaffirmed; 2000 Reaffirmed, 2005 Reaffirmed as Amended; 2010 Reaffirmed; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___*Referred to Bureau on Federal Health Programs*_____

DATE: ___July 19, 2025_________

SUBJECT: FIREARMS AND NON-POWDERED GUNS – EDUCATION FOR USERS - SOURCE: H418-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports **COMPREHENSIVE**
8 education involving firearm and non-powdered guns safety ~~and the inherent risk,~~
9 ~~benefits and responsibility of ownership~~. [Editor's Note: Non-Powdered Guns are
10 defined as: BB, air and pellet guns, expelling a projectile (usually made of metal or
11 hard plastic) through the force of compressed air or gas, electricity, or spring action.
12 Non-powder guns are distinguished from firearms, which use gunpowder to
13 generate energy to launch a projectile.

Background Information: Provided by AOA Staff
Current AOA Policy: 1990; 1995 Reaffirmed; 2000 Reaffirmed; 2005 Reaffirmed; 2010 Reaffirmed as Amended; 2015 Reaffirmed as Amended; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: DRUGS, CURBING COUNTERFEIT - SOURCE: H426-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports the Food and Drug
8 Administration's (FDA) efforts to educate osteopathic physicians on how to identify
9 counterfeit drugs.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Revised; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: CONTINUED SUPPORT OF COMBATING BIO-TERRORISM ACTIVITIES - SOURCE: H432-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association supports any and all constitutionally legal
8 efforts to prevent and respond to future acts of bio-terrorism in the United States.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Adopted as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ______Adopted_____

DATE: ________July 19, 2025_________

SUBJECT: NATIONAL INSTITUTES OF HEALTH GRANTS
- SOURCE: H437-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) encourages osteopathic physicians,
8 osteopathic medical schools, and their affiliated institutions to pursue **NATIONAL**
9 **INSTITUTES OF HEALTH (**NIH**)** funding for biomedical research; and requests that
10 the NIH include osteopathic medical schools in the overall United States medical
11 school funding reports and also to include a category specific to Osteopathic
12 Manipulative Treatment (OMT) in the estimates of funding for various Research,
13 Condition, and Disease Categories (RCDC) reported each year to Congress and
14 the American public.

15 **THE AOA ADVOCATES FOR THE NIH TO REQUEST GRANT SUPPORT AND**
16 **ADEQUATE FUNDING FROM CONGRESS**.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: FIREARM VIOLENCE - SOURCE: H442-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

WHEREAS, the Bureau on Federal Health Programs believes that the policy remains relevant now, therefore be it

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

Policy Statement

~~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.~~

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.

Background Information: Provided by AOA Staff
Current AOA Policy: 2013; 2015 Revised; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: BACKGROUND CHECKS AND FIREARMS SAFETY TRAINING AS A CONDITION OF FIREARMS PURCHASE
- SOURCE: H446-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) recognizes public health data
8 demonstrating the impact of firearms on mortality and wellness in the United States
9 and will support federal legislation requiring comprehensive background checks for
10 all firearm purchases, including sales by gun dealers, sales at gun shows, and
11 online sales for purchase, which does not extend to firearms transfers between
12 family members or firearms attained through inheritance. The AOA will support
13 efforts to require firearms safety training, including military or law enforcement
14 training, as a condition to purchase any class of firearms.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: EPIDEMIC TERRORIST ATTACK VICTIMS, GOVERNMENT RESPONSIBILITY OF HEALTH CARE - SOURCE: H453-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports all healthcare personnel
8 and first responders and victims of domestic or foreign terrorist attacks in the United
9 States being eligible for healthcare treatment stemming from the act to be covered
10 by the United States Government.

Background Information: Provided by AOA Staff
Current AOA Policy: 2004; 2009 Reaffirmed as Amended; 2014 Reaffirmed; 2020 Adopted as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: SILVER ALERT SYSTEM - SOURCE: H436-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and
3 the American Osteopathic Association (AOA) supports the wide-spread
4 state adoption of emergency response systems for missing mentally
5 impaired adults throughout the United States, via "Silver Alert" and "Gold (or
6 golden) Alert" networks which are also known as "Endangered Person
7 Advisory Networks"; and

8 WHEREAS, the Bureau on Federal Health Programs believes that this policy is
9 duplicative of H416-A/24 Alert Network – Silver and Gold now, therefore be it

10 RESOLVED, that the Bureau on Federal Health Programs recommends the
11 following policy be SUNSET.

12 The American Osteopathic Association (AOA) supports the formation of a "Silver
13 Alert" System on a national level to notify communities of missing persons with
14 mental disabilities, particularly seniors with cognitive or developmental impairments.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic:
H416-A/24 – Alert Network-Silver and Gold

FISCAL IMPACT: $0

ACTION TAKEN: Sunset

DATE: July 19, 2025

SUBJECT: PUBLIC EDUCATION REGARDING THE IMPORTANCE AND SAFETY OF VACCINES FOR INFANTS, CHILDREN, AND ADULTS - SOURCE: H-402/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___*Referred to Bureau of Osteopathic Research and Public Health*__

DATE: ___July 19, 2025_____________

SUBJECT: SUPPORT FOR THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) RECOMMENDATIONS
- SOURCE: H-403/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: *Referred to Bureau of Osteopathic Research and Public Health*

DATE: July 19, 2025

SUBJECT: ANTIBIOTIC STEWARDSHIP - SOURCE: H-406/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

The American Osteopathic Association (AOA) supports the five core actions outlined **BELOW BY** ~~in~~ the National Strategy for Combating Antibiotic-Resistant Bacteria and calls upon osteopathic physicians **AND THEIR COLLABORATING CARE EXTENDERS (NP/PA ETC)** to adopt the principles of responsible antibiotic use, or antibiotic stewardship, which is a commitment to use antibiotics only when they are medically necessary.

1. **SLOW THE EMERGENCE OF RESISTANT BACTERIA AND PREVENT THE SPREAD OF RESISTANT INFECTIONS;**

2. **STRENGTHEN NATIONAL ONE-HEALTH SURVEILLANCE EFFORTS TO COMBAT RESISTANCE;**

3. **ADVANCE DEVELOPMENT AND USE OF RAPID AND INNOVATIVE DIAGNOSTIC TESTS FOR IDENTIFICATION AND CHARACTERIZATION OF RESISTANT BACTERIA;**

4. **ACCELERATE BASIC AND APPLIED RESEARCH AND DEVELOPMENT FOR NEW ANTIBIOTICS, OTHER THERAPEUTICS, AND VACCINES; AND**

5. **IMPROVE INTERNATIONAL COLLABORATION AND CAPACITIES FOR ANTIBIOTIC RESISTANCE PREVENTION, SURVEILLANCE, CONTROL, AND ANTIBIOTIC RESEARCH AND DEVELOPMENT.**

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: ____July 19, 2025____________

SUBJECT: VACCINES FOR CHILDREN PROGRAM
- SOURCE: H-407/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association (AOA) supports ~~the expansion of~~ the
9 Vaccines for Children (VFC) Program to include all Advisory Committee on
10 Immunizations Practices (ACIP) age-appropriate vaccines for all underinsured
11 children, in keeping with the original goals of the program.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Reaffirmed as Amended; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: *Referred to Bureau of Osteopathic Research and Public Health*

DATE: July 19, 2025

SUBJECT: INTRAUTERINE FETAL DEMISE AWARENESS
- SOURCE: H-409/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports increasing public
7 awareness of the risk for intrauterine fetal demise and encourages the director of
8 the National Institutes of Health to allocate more resources to intrauterine fetal
9 demise research.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_______

DATE: ____July 19, 2025___________

SUBJECT: ANIMALS IN MEDICAL RESEARCH - SOURCE: H-412/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports the use of animals for valid
7 medical research projects and the humane handling and treatment of such animals,
8 and their ready availability from legitimate sources. The AOA supports eventual
9 elimination of the use of animals in medical research as better techniques become
10 available.

Background Information: Provided by AOA Staff
Current AOA Policy: 1990; 1995 Reaffirmed; 2000 Reaffirmed as Amended; 2005 Reaffirmed as Amended; 2010 Reaffirmed; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: CANCER - SOURCE: H-413/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association (AOA) recognizes, endorses, and approves
9 the continuing efforts of the National Cancer Institute to develop means to
10 significantly reduce the incidence of cancer and the suffering and death resulting
11 from cancer. ~~THE AOA will disseminate to the medical community and the public~~
12 ~~information gained from osteopathic and other research activities on the~~
13 ~~applications of the latest advances in cancer prevention, detection, early diagnosis~~
14 ~~and treatment.~~

Background Information: Provided by AOA Staff
Current AOA Policy: Status: 1974; 1980 Reaffirmed, 1985 Reaffirmed; 1990 Reaffirmed as Amended, 1995, 2000 Reaffirmed, 2005 Reaffirmed as Amended; 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: CARDIOPULMONARY RESUSCITATION, TRAINING
- SOURCE: H-414/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) strongly supports instruction in
7 Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED)
8 training to the general public; and encourages member physicians to qualify as
9 instructors in basic life support so as to enable them to teach ~~Cardiopulmonary~~
10 ~~Resuscitation~~ **CPR** and AED courses on a voluntary basis.

Background Information: Provided by AOA Staff
Current AOA Policy: 1980; 1985 Reaffirmed as Amended; 1990 Reaffirmed; 1995 Reaffirmed; 2000 Reaffirmed; 2005 Reaffirmed; 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: CHILDREN'S SAFETY SEATS - SOURCE: H-415/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy and determined that this policy is covered under resolution H419-
4 A/24 Occupant Protection in Passenger Vehicles (SR-Source-H427-A/19),
5 now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that this policy be SUNSET.

8 The American Osteopathic Association (AOA) supports the adoption and
9 enforcement of child safety seat statutes in accordance with the National Highway
10 Traffic Safety Administration Guidelines.

Background Information: Provided by AOA Staff
Current AOA Policy: 1990 Reaffirmed as Amended; 1995 Reaffirmed; 2000 Reaffirmed as Amended; 2005 Reaffirmed; 2010 Reaffirmed as Amended; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic:
H419-A/24 Occupant Protection in Passenger Vehicles

FISCAL IMPACT: $0

ACTION TAKEN: _Sunset_____________

DATE: ___July 19, 2025______________

SUBJECT: ENVIRONMENTAL RESPONSIBILITY--WASTE MATERIALS - SOURCE: H-417/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports recycling

Background Information: Provided by AOA Staff
Current AOA Policy: 1995; 2000 Reaffirmed as Amended; 2005 Reaffirmed as Amended; 2010 Reaffirmed as Amended; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: GENETIC MANIPULATION OF FOOD PRODUCTS – CONSUMERS RIGHT TO KNOW - SOURCE: H-419/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports efforts that require clear
7 identification of any genetically manipulated food products so that consumers may
8 be properly informed as they make food choices.

Background Information: Provided by AOA Staff
Current AOA Policy: 2000, 2005 Reaffirmed as Amended, 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: CONDOM USAGE – HEALTH EDUCATION
- SOURCE: H-420/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports full disclosure of the risks
7 and benefits of condom usage and the data on condom failure rates and causes of
8 failure, whenever condom usage is taught.

Background Information: Provided by AOA Staff
Current AOA Policy: 1995; 2000 Reaffirmed as Amended; 2005 Reaffirmed, 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: SUPPORT OF LITERACY PROGRAMS - SOURCE: H-421/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports programs that promote
7 literacy in the United States.

Background Information: Provided by AOA Staff
Current AOA Policy: 1990; 1995 Reaffirmed as Amended; 2000 Reaffirmed, 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_______

DATE: _____July 19, 2025_________

SUBJECT: HEALTHY FAMILY, SUPPORT OF - SOURCE: H-424/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) recommends that their members
7 support healthy families by encouraging families to do the following, **BUT NOT**
8 **LIMITED TO**:

9 1. Try to eat at least one meal per day together, using healthful nutritional
10 guidelines

11 2. A set time be spent together as a family to help with school work and include
12 reading to and with children

13 3. Encouraging media-free time

14 4. Limiting exposure to violence

15 5. Engaging in a healthy lifestyle that includes exercise

16 **6. OBTAINING ADEQUATE SLEEP**

17 **7. AVOIDING HARMFUL SUBSTANCES**

Background Information: Provided by AOA Staff
Current AOA Policy: 2010 Revised; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025_____________

SUBJECT: IMMUNIZATION OF 9 TO ~~26~~ **45** YEAR OLD MALE AND FEMALES WITH HUMAN PAPILLOMA VIRUS VACCINE - SOURCE: H-425/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports education and immunization
7 for Human Papilloma Virus (HPV).

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended
DATE: July 19, 2025

SUBJECT: SLEEP DISORDERS - PROMOTING THE UNDERSTANDING AND PREVENTION OF - SOURCE: H-427/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports programs that promote
7 education and understanding of sleep and its impact on health and encourages
8 osteopathic physicians to educate their patients about sleep disorders and the
9 importance of sleep and its impact on health.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Revised; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: MINORITY HEALTH DISPARITIES - SOURCE: H428-A2020

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8

9 The American Osteopathic Association (AOA) adopts the following Position
10 Statement on Minority Health Disparities.

11

12 MINORITY HEALTH DISPARITIES

13 The minority healthcare crisis in America stems from a multitude of factors. In
14 particular, healthcare disparities most greatly affect underrepresented minorities,
15 which include African-Americans, Hispanic-Americans, Asian-Americans, Native
16 Americans and Pacific Islanders. In order to effectively create positive change,
17 certain questions must be addressed. These include, but are not limited to: Which
18 minorities are most affected by disease-specific illness? Why do these disparities
19 exist? What can be done to eliminate them? Will a concerted effort to increase
20 awareness and education about health-care disparities result in improved delivery
21 of quality healthcare?

22 There is a need for the osteopathic profession and all of organized medicine to
23 develop strategies which address health care disparities among minorities and
24 prepare culturally competent physicians. Guidance should be offered to educate
25 practicing physicians and trainees to better resolve known disparities and serve
26 diverse populations. Efforts must be made to assure cultural competency and to
27 identify and overcome language and other barriers to delivering health care to
28 minorities.

29 Healthcare disparities include differences in health coverage, health access and
30 quality of care. Health disparities result in morbidity and mortality experienced by
31 one population group in relation to another.

32 Cultural competency is a set of academic and personal skills that allow one to
33 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. **REACH GRANTS HAVE BEEN FUNDED THROUGH 2028.**

~~The identified~~ **A**reas 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); ~~and~~ 6) child and adult immunizations; **AND 7).** ~~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~~ **SUPPORTS** the following actions ~~to be taken~~ to address minority health disparities and to improve cultural competency of its physician members:

1. The education of physicians regarding racial and ethnic healthcare needs, including disparities in the areas listed above.
2. 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.

74 9. The adoption of strategies to assist physicians to effectively communicate
75 with their patients, addressing translation and other barriers to patient
76 understanding.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: *Referred to Bureau of Osteopathic Research and Public Health*

DATE: July 19, 2025

SUBJECT: INFANT WALKER (MOBILE) – BAN ON THE MANUFACTURE, SALE AND USE OF - SOURCE: H-429/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports the ban on the manufacture,
7 sale and use of mobile infant walkers; and urges osteopathic physicians to educate
8 parents and other caregivers on the risks associated with using these devices.

Background Information: Provided by AOA Staff
Current AOA Policy: 2003; 2010 Revised; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted_______

DATE: ____July 19, 2025___________

SUBJECT: DEVELOP IN-VITRO FERTILIZATION STANDARDS OF CARE - SOURCE: H-430/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports the appropriate and
7 evidence-based use of in-vitro fertilization in a manner that promotes the health and
8 safety of both the mother and embryo; and supports the ethical guidelines for the
9 practice of in-vitro fertilization that include, but are not limited to, the appropriate
10 number of embryos implanted per patient.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Not Adopted________

DATE: ____July 19, 2025____________

SUBJECT: CHILDHOOD OBESITY – WORSENING EPIDEMIC IN THE AMERICAN SOCIETY - SOURCE: H-433/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) encourages schools and vending
7 machine suppliers to include healthy choice snacks in vending machines; and
8 supports the limited use of vending machines in schools to avoid unnecessary
9 caloric intake.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: TEXTING WHILE DRIVING - SOURCE: H-435/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports efforts to educate all drivers
7 concerning the dangers of texting and driving and supports efforts to ban the use of
8 texting while driving.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted________

DATE: ____July 19, 2025___________

SUBJECT: INTERFERENCE IN THE PHYSICIAN-PATIENT RELATIONSHIP BY PERSONAL INJURY ATTORNEYS AND INSURANCE CARRIER AGEN~~TS~~**CIES** - SOURCE: H-400/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED.

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: SCREENING FOR BREAST CANCER - SOURCE: H-438/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) recognizes and promotes the
7 importance of the integrity of the patient-physician relationship and recommends
8 that breast cancer clinical preventive screenings and coverage be individualized to
9 the extent possible for every patient.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted________

DATE: ___July 19, 2025____________

SUBJECT: GENDER IDENTITY NON-DISCRIMINATION
- SOURCE: H-439/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) ~~supports the provision of adequate~~
7 ~~and medically necessary treatment for transgender and gender-variant people and~~
8 opposes discrimination on the basis of gender identity.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: TRAUMATIC BRAIN INJURY AWARENESS
- SOURCE: H-440/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association (AOA) **SUPPORTS THE BELIEF** ~~believes~~
9 that osteopathic physicians should ~~be aware of and~~ utilize ~~"~~best practices~~"~~ when
10 caring for victims of civil or military conflicts, or natural or man-made disasters,
11 including civilians, returning veterans and their families, particularly those with
12 Traumatic Brain Injury (TBI); ~~and the AOA will work in conjunction with state,~~
13 ~~specialty and regional societies to provide educational programs to advance this~~
14 ~~goal.~~

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: SUPPORT FOR FAMILY CAREGIVERS
- SOURCE: H-441/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
5 amendments to provide clarity and updates to the policy, now therefore be it

6 RESOLVED, that the Bureau of Osteopathic Research and Public Health
7 recommends that the following policy be REAFFIRMED AS AMENDED.

8 The American Osteopathic Association (AOA), ~~recognizing~~ **RECOGNIZES THAT** a
9 growing number of family caregivers have unaddressed needs related to personal
10 health and wellbeing, **AND** supports ~~caregivers by participating in the developing~~
11 ~~public debate regarding.~~ **A** health care policy **WHICH** ~~to~~ include**S** family caregivers
12 and encourages its members to gain education in caregiver illnesses, **SEEK**
13 resources in their area and treat and/ refer when appropriate.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: ADOPTING AND PROMOTING NON-STIGMATIZING LANGUAGE FOR SUBSTANCE USE DISORDERS - SOURCE: H-444/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) commit to the use of clinically-
7 accurate, non-stigmatizing, person-first language (including, but not limited to,
8 "substance use disorder," "recovery," "substance misuse," "positive or negative
9 urine screen," "person with a substance use disorder," and "recurrence of use") and
10 discourage the use of stigmatizing terminology in future publications, resolutions,
11 and educational materials both in print and online.

Background Information: Provided by AOA Staff
Current AOA Policy: 2020 Adopted

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: AOA RESPONSE TO **URGENT, EMGERGENT, AND** NOVEL PUBLIC HEALTH THREATS - SOURCE: H-445/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) will continue to serve as a trusted
7 source of information and education for physicians, health professionals and the
8 public relative to urgent, emergent and novel public health threats; and, that the
9 AOA will advocate for and support those responding to urgent, emergent and novel
10 public health threats, including all healthcare workers and volunteers; and, that the
11 AOA will advocate for proactive planning, improved public health infrastructure,
12 disease threat surveillance and evidence-based responses to **URGENT,**
13 **EMERGENT, AND** novel public health threats affecting the U.S. population

Background Information: Provided by AOA Staff
Current AOA Policy: 2020

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025_____________

SUBJECT: ~~HOMELESS~~ SUPPORT **FOR THOSE EXPERIENCING HOMELESSNESS** - SOURCE: H-449/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health added the
3 appropriate statement from resolution H405-A/23 Concerns in People with
4 Housing Insecurity (Source:H-428/A18) into this policy; and

5 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
6 amendments to provide clarity and updates to the policy, now therefore be it

7 RESOLVED, that the Bureau of Osteopathic Research and Public Health
8 recommends that the following policy be REAFFIRMED AS AMENDED.

9 The American Osteopathic Association (AOA) ~~reaffirm~~ supports ~~for~~:

10 1. State and federal efforts, including efforts by private organizations **TO**
11 **ADDRESS** ~~**HOMELESS**~~ **SUPPORT FOR THOSE EXPERIENCING**
12 **HOMELESSNESS**,

13 **2.** ~~as well as those enumerated in the 2018 House of Delegates resolution number~~
14 ~~H-428 – A/2018,~~ **PROGRAMS THAT ENSURE DELIVERY OF PRIMARY AND**
15 **PREVENTIVE HEALTHCARE TO ALL UNDERSERVED POPULATIONS,**
16 **INCLUDING THOSE EXPERIENCING HOMELESSNESS, AND**

17 3. ~~and that those~~ Efforts ~~include~~ addressing social determinants affecting health,
18 substance ~~abuse~~ **USE DISORDER** programs, mental health resources, clinical
19 care programs, and provision of stable housing for all ~~homeless~~ individuals
20 **EXPERIENCING HOMELESSNESS** that are seeking temporary or permanent
21 shelter.

Background Information: Provided by AOA Staff
Current AOA Policy: 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: H405-A/23 Concerns in People with Housing Insecurity

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended___

DATE: __July 19, 2025________________

SUBJECT: BREASTFEEDING WHILE ON ~~MEDICATION ASSISTED TREATMENT (MAT)~~ **MEDICATIONS FOR OPIOID USE DISORDER (MOUD)** - SOURCE: H452-A/20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the current white paper addresses opioid use disorder and ~~medication assisted treatment~~ **MEDICATIONS FOR OPIOID USE DISORDER** and the importance of breastfeeding; and

WHEREAS, the American Osteopathic Association (AOA) has other policies addressing the same issues (H431-A22 AOA Policies on Opioids and Substance Use White Paper[1] and H402-A/23 Breastfeeding Exclusivity[2]); and

WHEREAS, the American College of Obstetricians and Gynecologists (ACOG)[3] **AMERICAN COLLEGE OF OSTEOPATHIC ACADEMY OF ADDICTION MEDICINE (AOAAM)** and the Academy of Breastfeeding Medicine (ABM)[4] recommend breastfeeding while on ~~medication assisted treatment~~ **MEDICATIONS FOR OPIOID USE DISORDER** with these recommendations being readily available on their respective websites, and

WHEREAS, after review of this information the Bureau of Osteopathic Research and Public Health recommend the revised policy statements in lieu of the white paper, now, therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

Breastfeeding While on ~~Medication Assisted Therapy (MAT)~~ **MEDICATIONS FOR OPIOID USE DISORDER (MOUD)**

THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) ADOPTS THE FOLLOWING POLICY STATEMENTS ON BREASTFEEDING WHILE ON MEDICATION ASSISTED TREATMENT (MAT):

1. **THE AOA ACKNOWLEDGES THAT EXCLUSIVE BREASTFEEDING SIGNIFICANTLY IMPROVES MATERNAL AND INFANT HEALTH OUTCOMES.**

2. **THE 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 UNCONTROLLED HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION AND/OR HEPATITIS C WITH OPEN/BLEEDING AND CRACKED NIPPLES.**

3. **THE AOA RECOMMENDS THE USE OF COUNSELING, COORDINATION OF CARE, AND SOCIAL SUPPORT FOR MOTHERS DURING PREGNANCY AND BREASTFEEDING IN THE POSTPARTUM PERIOD.**

References

1. H431-A22 AOA Policies on Opioids and Substance Use White Paper. https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy_H431-A-22_AOA_Policies_on_Opioids_and_Substance_Use-White_Paper.pdf

2. H402-A/23 Breastfeeding Exclusivity. https://osteopathic.org/index.php?aam-media=/wp-content/uploads/policies/Policy_H402-A-23_Breastfeeding_Exclusivity_(H425-A18).pdf

3. American College of Obstetricians and Gynecologists. Opioid Use and Opioid Use Disorder in Pregnancy, Number 711, August 2017, Reaffirmed 2021. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

4. Harris, et al. Academy of Breastfeeding Medicine Clinical Protocol #21: Breastfeeding in the Setting of Substance Use and Substance Use Disorder (Revised 2023). https://abm.memberclicks.net/assets/DOCUMENTS/PROTOCOLS/ABM%20Clinical%20Protocol%2021%20SUD_English.pdf

~~REFERRED RESOLUTION: Breastfeeding While on Medication Assisted Treatment (MAT) Policy Statement~~

~~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,~~

72 the Centers for Disease Control and Prevention (CDC) recorded a 333% national
73 increase in opioid use disorder (OUD) among pregnant women, with 6.5 cases of
74 opioid abuse per 1,000 hospital deliveries, compared to 1.5 cases in 1999.[1]
75 Opioid use during pregnancy is not uncommon; as many as 1 in 5 pregnant
76 women enrolled in Medicaid filled an opioid prescription during their pregnancy.[2]
77 Prenatal opioid exposure has been directly linked to adverse health outcomes for
78 mothers and babies across the nation. These adverse health outcomes include
79 increased maternal mortality and morbidity, poor fetal development, preterm
80 births, still births, birth defects, and increased incidence of Neonatal Abstinence
81 Syndrome (NAS).[3]

82 Studies have found that breastfeeding among women being treated for OUD offers
83 many benefits that can mitigate the impacts of OUD for the mother and infant.
84 Benefits include, but are not limited to, reduced hospital stays and decreased need
85 for morphine treatment in infants born with NAS.[4]

86 **Opioid Use Disorder Treatment**
87 Medication Assisted Treatment, or MAT, is defined as the use of medications in
88 combination with counseling and behavioral therapies to treat OUD and aid
89 patients in sustaining their recovery.[5] MAT may be utilized with pregnant women
90 to treat opioid use disorder and avoid the severe consequences associated with
91 untreated opioid use disorder or stopping opioid usage too quickly. The U.S. Food
92 and Drug Administration has approved three medications, buprenorphine,
93 methadone, and naltrexone for OUD treatment.[5]

94 Naltrexone is the newest therapy approved by the U.S. Food and Drug
95 Administration to treat opioid use disorder in pregnant women. Since it is also the
96 least studied therapy, there is a research gap regarding the safety and
97 effectiveness of naltrexone during pregnancy.[6] As a result, MAT for pregnant
98 women commonly entails the use of methadone or buprenorphine with naloxone,
99 in conjunction with coordinated care among behavioral therapists, OB-GYNs, and
100 addiction specialists.[7] Both methadone and buprenorphine treatment are
101 endorsed by the American College of Obstetricians and Gynecologists and the
102 American Society of Addiction Medicine as best practices for addressing opioid
103 use during pregnancy.[4]

104 Methadone, a long-acting opioid agonist that decreases the desire to take opioids,
105 was established as the standard of care in 1998 for treating OUD in pregnant
106 women. The Substance Abuse and Mental Health Service Administration
107 (SAMHSA) identified methadone as a safe drug to take while pregnant or preparing
108 for pregnancy, along with counseling and participation in social support programs.[8]
109

110 Recently, The American Society of Addiction Medicine (ASAM) recognized
111 Buprenorphine combined with Naloxone as the standard of care for the treatment
112 of women who are pregnant or breastfeeding with OUD. The American
113 Osteopathic Academy of Addiction Medicine (AOAAM) supports ASAM
114 consensus that the combination of Buprenorphine and Naloxone is regularly
115 used, safe, and effective.[9] Buprenorphine is the first medication to treat opioid use
116 disorder that was authorized to be administered in physician offices, resulting in
117 improved access to treatment.[10] Studies indicate that buprenorphine reduces
118 fluctuations in fetal levels of opioids, minimizes repeated prenatal withdrawal,
119 decreases overdoses, and limits drug interactions.[10]

120 Neonatal withdrawal, also called neonatal abstinence syndrome (NAS), is an
121 anticipated and treatable condition caused by perinatal exposure to opioids,
122 including methadone and the combination of buprenorphine with naloxone.[11]
123 Although NAS may still occur in infants whose mothers receive MAT, the
124 symptoms are milder than they would be without treatment.[4]

125 Postpartum, both infants and women on maintenance therapies can experience
126 greater benefits through breast feeding. Although trace amounts of both
127 methadone and buprenorphine have been found to seep into breast milk, research
128 has shown that the benefits of breastfeeding outweigh the negligible risk
129 associated with the medication that enters breast milk.[8, 10]

130 **Breastfeeding**
131 Because of the associated benefits, exclusive breastfeeding, without other
132 supplementation, is recommended for healthy women by both the American
133 Academy of Pediatrics and the World Health Organization for the first 6 months of
134 life.[12,13] Breastfeeding contributes to attachment between a woman and her infant,
135 encourages skin-to-skin contact.[11] The antibodies and hormones found in breast
136 milk defend the infant's immune system against illness and lower the risk of
137 asthma, leukemia, childhood obesity, lower respiratory infections, eczema,
138 diarrhea, vomiting, and Sudden Infant Death Syndrome.[14] Breastfeeding also
139 improves the health of mothers post-delivery, simultaneously, lowering potential
140 risk for diabetes, breast cancer, and ovarian cancer. Breast milk is also easier for
141 infants to digest and cost efficient for parents.[14]

142 The American Academy of Pediatrics (AAP) recommendation applies to women
143 who take methadone or buprenorphine as well, without regard for dosage.[15]
144 Breastfeeding among women who are opioid dependent is also encouraged by
145 both, the American College of Obstetricians and Gynecologists (ACOG) and the
146 American College of Osteopathic Obstetricians and Gynecologists (ACOOG), as
147 long as the women are taking methadone or buprenorphine consistently,
148 abstaining from illicit drugs, and have no underlying complexities or conditions,
149 such as human immunodeficiency virus (HIV) and or Hepatitis C with
150 open/bleeding and cracked nipples.[11] Additionally, The ACOOG supports the
151 ACOG committee review that women in the post-partum period who return to
152 using street drugs and are not on stable OUD therapy should restrain from
153 breastfeeding.[16] After 6 months, the AAP recommends continuation of
154 breastfeeding, alongside introduction of complementary foods during the first year
155 of life.[12]

156 In spite of these endorsements, less than 25% of mothers exclusively breastfeed
157 for 6 months in the United States.[12] Formula supplementation of breast milk is
158 commonly utilized. Supplementation is reportedly associated with many side
159 effects that can lead to adverse infant and maternal outcomes. Formula
160 supplements can negatively impact the "maternal milk supply, the duration of
161 exclusive breastfeeding, and the infant's gut microbiome; alteration of the neonatal
162 gut environment can be responsible for mucosal inflammation and disease,
163 autoimmunity disorders, and allergic conditions in both childhood and
164 adulthood".[17]

165 The Centers for Disease Control and Prevention established the breastfeeding
166 report card, which provides national data on breastfeeding rates, breastfeeding
167 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~~

215 pregnancy and breastfeeding in the postpartum period.

216 References:

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Background Information: Provided by AOA Staff
Current AOA Policy: 2020

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: UNDERREPRESENTED MINORITIES – INCREASING NUMBERS OF APPLICANTS, GRADUATES AND FACULTY AT COLLEGES OF OSTEOPATHIC MEDICINE - SOURCE: H-454/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, excluding 2020 and 2022, there has been a steady increase in
5 **UNDERREPRESENTED MINORITIES (**URM**)** Applicants from 2019 to 2024.
6 Excluding 2021 and 2022, there has been a steady increase in matriculants
7 from 2019 to 2024; and

8 WHEREAS, comparing 2021-22 graduates to 2022-2023 graduates, the URM for
9 graduation increased by 2.6%; however, there was a demographic decline
10 for American Indian/Alaska Native, Black/African American, and non-
11 Hispanic compared to 2021-2022 graduates; and

12 WHEREAS, the Bureau of Osteopathic Research and Public Health has provided
13 amendments to provide clarity and updates to the policy, now therefore be it

14 RESOLVED, that the Bureau of Osteopathic Research and Public Health
15 recommends that the following policy be REAFFIRMED AS AMENDED.

16 The American Osteopathic Association (AOA) encourages **EFFORTS TO RECRUIT**
17 **AND TRAIN QUALIFIED URM STUDENT APPLICANTS AND FACULTY BY**
18 **COLLEGES OF OSTEOPATHIC MEDICINE.** ~~an increase in the total number of~~
19 ~~URM1 graduates **AND FACULTY** from colleges of osteopathic medicine by the year~~
20 ~~2020 and encourages an increase in the total number of URM faculty by the year~~
21 ~~2025 **2030**~~

<u>Background Information: Provided by AOA Staff</u>
Current AOA Policy: 2014; 2020 Adopted as Amended

Prior HOD action on similar or same topic: None

<u>FISCAL IMPACT</u>: $0

References:
Applicants & Matriculants by Race/Ethnicity 2009-2024:
https://www.aacom.org/searches/reports/report/applicants-matriculants-by-race-ethnicity-2009-2024
Osteopathic Medical College Graduates by Race/Ethnicity 2000-2023:
https://www.aacom.org/searches/reports/report/osteopathic-medical-college-graduates-by-race-ethnicity-2000-2023

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025_____________

SUBJECT: REGULATION OF E-CIGARETTES AND NICOTINE VAPING - SOURCE: RESOLUTION NO. H455-A/20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy; and

4 WHEREAS, the current white paper provides detailed information on e-cigarettes
5 and vaping, and their health consequences and regulation; and

6 WHEREAS, the CDC website includes numerous pages that are devoted to nicotine
7 and other potential harms of e-cigarettes, nicotine addiction and withdrawal,
8 and the impact of e-cigarettes and vaping on youth[1-3]; and

9 WHEREAS, the FDA website has detailed information about the regulation of e-
10 cigarettes, vapes, and other Electronic Nicotine Delivery Systems (ENDS)[4];
11 and

12 WHEREAS, after reviewing this information, the Bureau of Osteopathic Research
13 and Public Health recommends the updated policy statements in lieu of the
14 white paper, now, therefore be it

15 RESOLVED, that the Bureau of Osteopathic Research and Public Health
16 recommends that the following policy be REAFFIRMED AS AMENDED.

17 **REGULATION OF E-CIGARETTES AND NICOTINE VAPING**
18
19 **THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) ADOPTS THE**
20 **FOLLOWING POLICY STATEMENTS ON E-CIGARETTES AND VAPING:**
21
22 **1. THE AOA SUPPORTS FDA AND STATE REGULATION OF THE**
23 **INGREDIENTS IN ALL ELECTRONIC CIGARETTE CARTRIDGES,**
24 **REQUIRING INGREDIENT LABELS AND WARNINGS, AND**
25 **ELIMINATING THE USE OF FLAVORS THAT ARE BANNED IN**
26 **TRADITIONAL CIGARETTES.**
27
28 **2. THE AOA SUPPORTS FDA AND STATE REGULATION PROHIBITING**
29 **SALES AND ADVERTISEMENTS OF ELECTRONIC CIGARETTES TO**
30 **PERSONS UNDER THE AGE OF 21. ADVERTISEMENTS FOR**
31 **ELECTRONIC CIGARETTES SHOULD BE SUBJECT TO THE SAME**
32 **RULES AND REGULATIONS THAT ARE ENFORCED ON**

33 **TRADITIONAL CIGARETTES.**
34
35 **3. THE AOA FURTHER ENCOURAGES FEDERAL, STATE AND LOCAL**
36 **GOVERNMENT ACTION TO BAN THE USE OF ELECTRONIC**
37 **CIGARETTE DEVICES IN ALL SPACES WHERE TRADITIONAL**
38 **CIGARETTES ARE CURRENTLY BARRED FROM USE.**
39
40 **4. THE AOA PROMOTES TOBACCO AND NICOTINE CESSATION**
41 **TREATMENT, AND THE USE OF ANY SUCH TREATMENT THAT**
42 **HAS BEEN PROVEN SAFE AND EFFECTIVE BY THE US FOOD AND**
43 **DRUG ADMINISTRATION (FDA). THERE IS CURRENTLY NO E-**
44 **CIGARETTE APPROVED BY THE FDA TO HELP PEOPLE QUIT**
45 **SMOKING.**
46
47 **5. THE AOA SUPPORTS RESEARCH BY THE FDA AND OTHER**
48 **ORGANIZATIONS INTO THE HEALTH AND SAFETY IMPACT OF E-**
49 **CIGARETTES AND LIQUID NICOTINE.**
50
51 **6. THE AOA ENCOURAGES PHYSICIANS TO EDUCATE PATIENTS**
52 **ABOUT THE RISKS OF E-CIGARETTE USE, AND TO COUNSEL**
53 **PATIENTS TO SUBMIT VOLUNTARY REPORTS TO THE US**
54 **DEPARTMENT OF HEALTH AND HUMAN SERVICES SAFETY**
55 **REPORTING PORTAL (WWW.SAFETYREPORTING.HHS.GOV) IF**
56 **THEY SUSTAIN ADVERSE REACTIONS TO E-CIGARETTES.**
57
58 **7. THE AOA DISCOURAGES THE PLACEMENT OF MEDICAL**
59 **PRACTICES AND LIMITED-SERVICE CLINICS IN RETAIL SETTINGS**
60 **THAT PROMOTE AND SELL TOBACCO.**
61

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74 ~~REGULATION OF E-CIGARETTES AND NICOTINE VAPING~~
75
76 **~~BACKGROUND~~**

77 The adverse health effects associated with tobacco use are well documented public
78 health concerns. Smoking can damage every human organ, and it can lead to death
79 from heart disease, cancers or strokes. According to the World Health Organization
80 (WHO), 1 in 10 deaths each year, or nearly 8 million deaths around the world, are
81 caused by tobacco use.[1,2] More than 7 million of those deaths are the result of direct
82 tobacco use, while around 1.2 million are the result of non-smokers being exposed
83 to second-hand smoke.[2] In the United States, this translates to 480,000 deaths per
84 year from cigarette smoking and second-hand smoke exposure.[3]
85
86 In response to the negative health effects of tobacco products and cigarettes in
87 particular, a natural market for smoking cessation and reduction products has
88 emerged over the past 4 decades.[4] The use of electronic nicotine delivery systems
89 (ENDS), such as electronic cigarettes (e-cigarettes), has reached a rapidly expanding
90 consumer base.[5] E-cigarettes are often used or promoted to reduce consumption of
91 tobacco products.[6] Alternative strategies for reaching smoking cessation goals include
92 switching to low or light cigarettes or using nicotine-infused chewing gum, lozenges,
93 lollipops, dermal patches or hypnosis.[7]
94
95 In the US, e-cigarettes are the most frequently utilized tobacco product among
96 youth, who are also more likely than adults to use them. In 2019, over 5 million US
97 middle and high school students had used e-cigarettes in the past 30 days.[8] In 2018,
98 3.2% of US adults were current e- cigarette users.[9]
99
100 The name e-cigarette is an umbrella term that includes any battery-powered device
101 that vaporizes liquid nicotine for delivery via inhalation. These devices are most
102 commonly referred to as electronic cigarettes, e-cigarettes, e-cigs, vaping, vape pens,
103 vape pipes, hookah pens, e- hookahs, but could potentially be referred to by other
104 terms. Since its 2007 introduction in the United States, the e-cigarette market has
105 grown to include more than 460 brands.[10] E-cigarettes are a 2.5 billion dollar business
106 in the United States.[11] The attraction to e-cigarettes crosses many segments of the
107 population, appealing to tobacco cigarette smokers trying to quit as well as non-
108 smokers who want to try nicotine without the harmful additives.[12] Though some states
109 and municipalities have started to ban e-cigarettes, tobacco cigarette smokers can
110 use e- cigarettes as a source of nicotine in some venues where conventional
111 cigarettes are banned.
112
113 Costs associated with smoking-related illnesses continue to escalate. In 2014,
114 smoking-related illness costs in the United States were more than $300 billion each
115 year, including approximately $170 billion for direct medical care for adults, and more
116 than $156 billion in lost productivity. Nearly $5.6 billion of the lost productivity cost was
117 due to secondhand smoke exposure.[13]

118 Overall, e-cigarettes may be less harmful for heavy or moderate smokers because
119 they may reduce exposure to carcinogens and other toxic chemicals that cause
120 serious disease and death.[14] However, the effect of long term consumption of nicotine
121 and associated aerosols remains unclear. Studies have shown that e-cigarette vapors
122 may be harmful, particularly in places with limited ventilation and for people with
123 compromised health. Furthermore, e-juice liquids have been found to increase
124 accidental poisonings in children. The full scale of health and safety hazards of vaping
125 for users and secondhand users is undetermined.[15]
126
127 **ANALYSIS**

128 Regulation of e-cigarettes by the Food and Drug Administration (FDA) only began in
129 earnest in 2016. The Family Smoking Prevention and Tobacco Control Act (Tobacco
130 Control Act) provided the FDA authority to regulate the manufacture, marketing and
131 distribution of tobacco products.[16] However, e-cigarettes were not initially included in the
132 FDA's regulation of tobacco products. Unlike tobacco cigarettes, e-cigarettes have
133 enjoyed the ability to advertise on television and radio.[17] This allows e-cigarette
134 companies to market their product in a more liberal fashion in response to market
135 demands, including the use of celebrity endorsements.[18] However, some manufacturers
136 have voluntarily begun to limit their advertising in an attempt to avoid federally imposed
137 restrictions on advertising.
138
139 The Composition of E-Cigarettes
140 The e-cigarette is a smokeless, battery-powered device that vaporizes liquid nicotine
141 for delivery via inhalation.[19] Using an e-cigarette may also be referred to as "vaping", or
142 as "juuling", the branded form of flavored e-cigarettes popular among younger
143 consumers. The e-cigarette contains nicotine derived from tobacco plant and several
144 secondary chemical ingredients.[20] It is primarily composed of a nicotine cartridge,
145 atomizer, and a battery.[21] The atomizer, which converts the nicotine liquid into a fine
146 mist, consists of a metal wick and heating element.[22] When screwed onto the cartridge,
147 the nicotine liquid from the cartridge, which could also include flavoring, comes into
148 contact with the atomizer unit and is carried to the metal coil heating element.[23] A single
149 cartridge can hold the nicotine equivalent of an entire pack of traditional cigarettes.[24] E-
150 cigarettes can also be used to deliver marijuana and other drugs.[25]
151
152 While the typical e-cigarette is sold in the shape of a cigarette, many products are sold
153 in the shape of discreet objects such as pipes, pens, lipsticks, and other everyday
154 items.[26] Often, they can be legally used where traditional tobacco products are
155 banned.
156
157 Federal Efforts to Regulate
158 In 2016, the FDA finalized a rule extending regulatory authority to cover all tobacco
159 products, including electronic nicotine delivery systems (ENDS) that meet the
160 definition of a tobacco product.[27] The FDA now regulates the manufacture, import,
161 packaging, labeling, advertising, promotion, sale, and distribution of ENDS. Prior to
162 this rule, the FDA could regulate e-cigarettes only if the manufacturer made a
163 therapeutic claim, such as the product was being marketed as a cessation device.[28]
164
165 The rule established restrictions on youth access to newly regulated tobacco
166 products by: (1) banning their sale to individuals younger than 18 years of age
167 (federal legislation raised this to 21 years in 2019) and requiring age verification via
168 photo ID; and (2) prohibiting the sale of tobacco products in vending machines
169 (unless in an adult-only facility).[29]
170
171 The Federal Food, Drug, and Cosmetic Act was signed into law on December 20,
172 2019, and raised the federal minimum age of sale for tobacco products from 18 to 21
173 years.[30] Retailers are now prohibited from selling tobacco products to anyone under
174 the age of 21.
175
176 Further, in January 2020, the FDA banned all mint- and fruit-flavored e-cigarettes,
177 but exempted menthol- and tobacco-flavored products, in an effort to target products
178 widely used by minors while preserving an "off-ramp" for adults who are trying to quit

179 smoking.[31]
180
181 Tobacco is a major threat to public health, and one of the goals of the FDA is to
182 protect Americans from tobacco-related diseases and death. This rule allows the FDA
183 to protect youth by restricting their access to tobacco products, helps consumers
184 better understand the risks of using these products, prohibits false and misleading
185 product claims, and prevents new tobacco products from being marketed unless a
186 manufacturer demonstrates that the product meets relevant public health standards.
187
188 State Efforts to Regulate
189 Various states and municipalities have also enacted laws restricting the sale of e-
190 cigarettes.[32] Twenty-seven states, along with the District of Columbia, Puerto Rico,
191 and the U.S. Virgin Islands, and 1,107 municipalities have passed laws that ban
192 smoking in all non-hospitality workplaces, restaurants, and bars; of these, 22 states
193 and 929 municipalities also restrict e- cigarette use in 100% smoke-free venues.[33]
194
195 In November 2019, **Massachusetts** became the first state to restrict the sale of *all*
196 flavored tobacco products, including e-cigarettes and menthol cigarettes.[34] **New**
197 **Jersey** prohibited the use of e-cigarettes in all enclosed indoor places of public
198 access as well as in working places, and in January 2020, the state enacted
199 legislation banning the sale of *all* flavored e- cigarettes.[35,36] In March 2020, **Rhode**
200 **Island** also announced a permanent ban on the sale of flavored e-cigarettes.[37] Six
201 other states (Michigan, Montana, New York, Oregon, Utah and Washington)
202 temporarily banned the sale of flavored e-cigarettes in 2019, but of those, only
203 Montana's and Washington's bans are currently in effect while the others are facing
204 various legal challenges.[38]
205
206 As of 2019, twenty-three (23) states and the District of Columbia have enacted
207 statutes which require licenses for retail sales of e-cigarettes.[39]
208
209 Arguments for E-Cigarettes
210 Proponents of e-cigarettes consider e-cigarettes to be less harmful than traditional
211 tobacco products and believe they increase adult smoking cessation.[40] While it has
212 been established that e-cigarettes contain fewer carcinogenic elements than traditional
213 tobacco cigarettes, the long-term health effects of e-cigarette use are unknown.[41]
214 According to the American Lung Association there are approximately 600 ingredients in
215 cigarettes.[42] When burned, they create more than 7,000 chemicals.[43] At least 69 of
216 these chemicals are known to cause cancer, and many are poisonous.[44] While e-
217 cigarettes may have fewer component chemicals, a study found that the usage of e-
218 cigarettes contributes to indoor air contamination.[45] A 2016 report from the WHO
219 determined that second-hand aerosols from e-cigarettes are a new source of pollution
220 for hazardous particulate matter (PM). The levels of nickel, chromium, and other metals
221 found in second-hand aerosols are higher than ambient air and higher than second-
222 hand tobacco smoke.[46]
223
224 The greatest appeal of e-cigarettes for smoking cessation is that they deliver nicotine
225 to alleviate nicotine withdrawal symptoms. E-cigarettes evoke the psychological
226 response to cigarette smoking because of its shape and the familiar behavior aspect
227 of smoking.[47] A 2011 survey of 104 e-cigarette users revealed that 66% started using
228 them with the intention to quit smoking and almost all felt that the e-cigarette had
229 helped them to succeed in quitting smoking.[48] Another survey of 3,037 e-cigarette
230 users revealed that 77% of respondents used e- cigarettes to quit smoking or to avoid

231 relapse.[49] None said they used them to reduce consumption of tobacco with no intent
232 to quit smoking.[50] However, the overall effectiveness of e- cigarettes is still in question.
233 In a randomized study, participants given e-cigarettes, nicotine patches and placebo
234 e-cigarettes that lacked nicotine were able to quit smoking at roughly the same rates,
235 with insufficient statistical power to conclude superiority of nicotine e-cigarettes.[51]
236
237 Consequences of E-Cigarettes
238 Advocates of e-cigarettes contend that e-cigarettes are less risky than traditional
239 tobacco products and can serve as a mode of harm reduction by reducing smoking or
240 serving as a smoking cessation strategy.[52] While there is limited evidence that
241 suggests that adult smokers could benefit from e-cigarette use instead of combustible
242 tobacco products, smokers would need to fully switch to e-cigarettes and stop
243 smoking cigarettes and other tobacco products completely to achieve any meaningful
244 health benefits from e-cigarettes. Experts who serve on the US Preventive Services
245 Task Force have resolved that there is insufficient evidence to recommend e-
246 cigarettes for smoking cessation in adults, including pregnant women. Thus, e-
247 cigarettes are not currently approved by the FDA as an aid to quit smoking.[53]
248
249 Another major concern is that e-cigarettes appeal to youth by being flavorful, trendy
250 and a convenient accessory.[54] The flavorings being used, such as candy and other
251 sweet flavorings are particularly attractive to younger populations. For this reason,
252 these flavorings are banned in traditional cigarettes.[55] Despite a downturn prior to
253 2017, e-cigarette use among youth has drastically increased. From 2017 to 2018,
254 the percent of middle school students who used e- cigarettes increased 48%,
255 resulting in 570,000 middle school students, or 4.9%, who were current e-cigarette
256 users. Among high school students during the same period, current e- cigarette use,
257 defined as use at least one day in the past 30 days, increased by 78%, from 11.7%
258 to 20.8%, the equivalent of 3.05 million high school students using e-cigarettes in
259 2018. Current e-cigarette users in high school who reported use on 20 days or more
260 in the past 30- day period increased from 20% to 27.7%. During the same
261 timeframe, use of flavored e- cigarettes increased among high school students who
262 currently used e-cigarettes as well. Use of any flavored e-cigarette went up among
263 current users from 60.9% to 67.8%, and menthol use increased from 42.3% to
264 51.2% among all current e-cigarette users, including consumers of multiple products,
265 and from 21.4% to 38.1% among those using only e-cigarettes. From 2018 to 2019,
266 the number of middle school and high school students who reportedly used e-
267 cigarettes in the past 30 days increased from a total of 3.6 million to 5.4 million
268 youth.[56]
269
270 In addition to exposure to the carcinogenic and toxic effects of tobacco, smokers
271 become addicted to the nicotine.[57] Nicotine addiction is characterized as a form of
272 drug dependence recognized in the Diagnostic and Statistical Manual of Mental
273 Disorders (DSM-V).[58] E-cigarette cartridges can contain up to 20 times the nicotine
274 of a single cigarette, and the process of vaping lacks the normal cues associated
275 with cigarette completion, such as the butt of the cigarette ending a dose.[59]
276
277 Conditioning has a secondary role in nicotine addiction. Smokers associate
278 particular cues with the high of smoking, often causing relapse when those seeking
279 to quit smoking are confronted with those cues.[60] E-cigarettes allow quitting smokers
280 to respond to those cues. This poses a risk of overconsumption. The lack of finality
281 to an e-cigarette is determined only by the battery or nicotine cartridge.

282 Distinguishable from tobacco cigarettes, smokers who have turned to the e-
283 cigarette no longer have the butt of the cigarette as a cue to stop smoking.[61]
284
285 E-cigarettes can cause other inadvertent injuries as well. The CDC, the US Food
286 and Drug Administration (FDA), state and local health departments, and other
287 clinical and public health organizations have investigated a national outbreak of e-
288 cigarette, or vaping, product use- associated lung injury (EVALI).[62] EVALI is an
289 inflammatory response in the lungs triggered by inhaled substances. EVALI has
290 been found to vary due to the substantial variety of products and ingredients used.
291 It may present as pneumonia or an inflammatory condition known as fibrinous
292 pneumonitis.[63] As of February 2020, 2,807 hospitalized EVALI cases or deaths
293 were reported to CDC from all 50 states, the District of Columbia, Puerto Rico and
294 U.S. Virgin Islands. Sixty-eight (68) deaths were confirmed in 29 states and the
295 District of Columbia. Vitamin E acetate, an additive in some THC-containing e-
296 cigarette products, was found to be strongly associated with the EVALI outbreak.[64]
297
298 Additionally, e-cigarettes are manufactured from metal and ion components that
299 introduce concerns about faulty products and malfunctions.[65] Defective e-cigarette
300 batteries have caused fires and explosions, some of which have resulted in serious
301 injuries. Lithium-ion batteries have reportedly overheated, caught fire or exploded; an
302 event known as thermal runaway. From 2015 to 2017, an estimated 2,035 e-cigarette
303 explosions and burn injuries presented to hospital emergency departments. Although
304 the explosions are relatively rare, they can cause severe injuries.[66]
305
306 **CONCLUSION**
307 The AOA supports FDA and state regulation of the ingredients in all electronic
308 cigarette cartridges, requiring ingredient labels and warnings, and eliminating the
309 use of flavors that are banned in traditional cigarettes.
310
311 The AOA supports FDA and state regulation prohibiting sales and advertisements of
312 electronic cigarettes to persons under the age of 21. Advertisements for electronic
313 cigarettes should be subject to the same rules and regulations that are enforced on
314 traditional cigarettes.
315
316 The AOA further encourages federal, state and local government action to ban the
317 use of electronic cigarette devices in all spaces where traditional cigarettes are
318 currently barred from use.
319
320 The AOA promotes tobacco and nicotine cessation treatment, and the use of any
321 such treatment that has been proven safe and effective by the FDA.
322
323 The AOA supports research by the FDA and other organizations into the health
324 and safety impact of e-cigarettes and liquid nicotine.
325
326 The AOA encourages physicians to educate patients about the risks of e-cigarette
327 use, and to counsel patients to submit voluntary reports to the US Department of
328 Health and Human Services Safety Reporting Portal (www.safetyreporting.hhs.gov)
329 if they sustain adverse reactions to e-cigarettes.
330
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<u>Background Information: Provided by AOA Staff</u>

Current AOA Policy: 2015, 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: SEAT BELT LAWS – PRIMARY ENFORCEMENT
- SOURCE: H408-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports the primary enforcement
8 seat belt laws in every state.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_________

DATE: ___July 19, 2025_____________

SUBJECT: DEATH - RIGHT TO DIE - SOURCE: H416-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

7 The American Osteopathic Association (AOA) believes that the decision to withhold
8 or withdraw treatment from a patient whose prognosis is terminal, or when death is
9 imminent, shall be based upon the wishes of the patient or their family or legal
10 representative if the patient lacks capacity to act on their own behalf as mandated
11 by applicable law.

Background Information: Provided by AOA Staff
Current AOA Policy: 1979; 1984 Reaffirmed as Amended; 1989 Reaffirmed; 1995 Reaffirmed; 2000 Reaffirmed; 2005 Reaffirmed; 2010 Reaffirmed as Amended; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted__________

DATE: __July 19, 2025______________

SUBJECT: TANNING DEVICES - SOURCE: H422-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

7 The American Osteopathic Association (AOA) supports education and legislation to
8 reduce the use of tanning devices except ~~where medically indicated~~.

Background Information: Provided by AOA Staff
Current AOA Policy: 1990; 1995 Revised; 2000 Reaffirmed, 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025______________

SUBJECT: TOBACCO SETTLEMENT FUNDS - SOURCE: H423-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

7 The American Osteopathic Association (AOA) supports the use of the tobacco
8 settlement fund exclusively for health care services, education and research.

Background Information: Provided by AOA Staff
Current AOA Policy: 2000, 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted______

DATE: ____July 19, 2025___________

SUBJECT: VACCINATION RATES – DAYCARE NOTIFICATION TO PARENTS - SOURCE: H404-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

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

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_______

DATE: ___July 19, 2025____________

SUBJECT: PROTECTING PATIENTS WITH PRIVATE INSURANCE FROM BALANCE BILLING - SOURCE: REFERED H402-A/24; SR H426-A/19

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, H402-A/24 (Source: H426-A/19) was referred to the Bureau on Federal
2 Health Programs at the 2024 House of Delegates; and

3 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

4 WHEREAS, the Bureau on Federal Health Programs believes that the policy
5 remains relevant,

6 WHEREAS, the No Surprises Act was enacted in December 2020 to protect
7 consumers from pervasive out-of-network surprise medical bills. Due to
8 ongoing litigation now, therefore be it

9 RESOLVED, that the Bureau on Federal Health Programs recommends that the
10 referred policy be REAFFIRMED.

11 The American Osteopathic Association (AOA) supports patients' right to access
12 emergency medical care at a reasonable cost; and supports a system in which
13 patients are removed from the process of resolving outstanding medical expenses
14 that is beyond their cost sharing responsibilities for in-network care; and, that
15 disputes over the reasonable cost for out of network emergency care be determined
16 by an independent, third party or arbitration.

Background Information: Provided by AOA Staff
Current AOA Policy: 2019; 2024 Referred

Prior HOD action on similar or same topic:
H402-A/24 – Referred to Bureau on Federal Health Programs

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted______

DATE: ____July 19, 2025___________

SUBJECT: **UNPASTEURIZED** RAW MILK **AND DAIRY PRODUCTS** – HEALTH RISKS **OF** – SOURCE: SR-H416-A/19; REFERRED-H413-A/24

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, the Bureau of Osteopathic Research and Public Health (BORPH)
2 submitted H416-A/19 Raw Milk - Health Risks to the 2024 House of
3 Delegates during the sunset review process and recommended that it be
4 reaffirmed; and

5 WHEREAS, the 2024 House of Delegates referred this policy back to BORPH and
6 requested that BORPH review current data and update the policy; and

7 WHEREAS, Koski L et al[1] published a paper in 2022 in Epidemiology and Infection
8 which supports findings of previously published reports indicating that state
9 laws resulting in increased availability of unpasteurized milk are associated
10 with more outbreak-associated illnesses and outbreaks; and

11 WHEREAS, the U.S. Food and Drug Administration (FDA)[2] published a document
12 on its website entitled “Raw Milk Misconceptions and the Danger of Raw Milk
13 Consumption,” which outlines 14 myths around raw milk and disputes these
14 myths based on scientific literature; and

15 WHEREAS, the Centers for Disease Control and Prevention (CDC)[3] states on its
16 website that: 1. Pasteurization is crucial for milk safety, killing harmful germs
17 that can cause illness; 2. Consuming raw milk can lead to serious health
18 risks, especially for certain vulnerable populations; 3. Drinking or eating
19 products made from raw milk can expose people to germs such as
20 *Campylobacter, Cryptosporidium, E. coli, Listeria, Brucella,* and *Salmonella*.
21 (as of 1-31-2025, accessed 4-2-2025); and

22 WHEREAS, the American Academy of Pediatrics[4] strongly supports the position of
23 the FDA and other national and international associations in endorsing the
24 consumption of only pasteurized milk and milk products for pregnant women,
25 infants, and children; now, therefore be it

26 RESOLVED, that the Bureau of Osteopathic Research and Public Health
27 recommends that the following policy be REAFFIRMED AS AMENDED.

28 **THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) ADOPTS THE**
29 **FOLLOWING POLICY STATEMENTS:**

30 **1. THE AOA SUPPORTS THE CONSUMPTION OF PASTEURIZED MILK**
31 **AND DAIRY PRODUCTS OVER THOSE THAT ARE RAW AND/OR**
32 **UNPASTEURIZED.**

33 **2. THE AOA AGREES WITH THE CDC, THE FDA, AND THE AMERICAN**
34 **ACADEMY OF PEDIATRICS THAT DRINKING RAW MILK AND**
35 **CONSUMING UNPASTEURIZED DAIRY PRODUCTS CAN LEAD TO**
36 **SERIOUS HEALTH RISKS, ESPECIALLY FOR CERTAIN VULNERABLE**
37 **POPULATIONS, INCLUDING INFANTS, CHILDREN, THE ELDERLY,**
38 **PEOPLE WITH WEAKENED IMMUNE SYSTEMS, AND PREGNANT**
39 **WOMEN.**

40 **3. THE AOA ENCOURAGES OSTEOPATHIC PHYSICIANS TO EDUCATE**
41 **THEIR PATIENTS ON THE SAFETY CONCERNS AND THE HEALTH**
42 **RISKS OF CONSUMING RAW MILK AND THE BENEFITS OF**
43 **CONSUMING PASTEURIZED MILK AND DAIRY PRODUCTS IF AND**
44 **WHEN APPROPRIATE.**

45 **4. THE AOA SUPPORTS CONTINUED RESEARCH INTO THE SAFETY,**
46 **MICROBIOME EFFECTS, AND OVERALL HEALTH OUTCOMES OF RAW**
47 **MILK CONSUMPTION TO GUIDE EVIDENCE-BASED**
48 **RECOMMENDATIONS.**

49 **5. THE AOA ENCOURAGES COLLABORATION BETWEEN THE CDC, THE**
50 **FDA, PUBLIC HEALTH AGENCIES, RAW MILK PRODUCERS, AND**
51 **CONSUMERS TO DEVELOP STANDARDIZED SAFETY PRACTICES FOR**
52 **RAW MILK INTENDED FOR DIRECT HUMAN CONSUMPTION,**
53 **INCLUDING TESTING, CERTIFICATION, AND TRANSPARENT**
54 **LABELING.**

55 ~~The American Osteopathic Association (AOA) believes that all milk sold for human~~
56 ~~consumption should be required to be pasteurized; and encourages osteopathic~~
57 ~~physicians to educate their patients on the safety concerns and the health risks of~~
58 ~~consuming raw milk~~.

References:

1. Koski L et al (2022). Foodborne illness outbreaks linked to unpasteurized milk and relationship to changes in state laws – United States, 1998–2018. Epidemiology and Infection 150, e183,1–13. https://doi.org/10.1017/S0950268822001649

2. FDA. Raw Milk Misconceptions and the Danger of Raw Milk Consumption. https://www.fda.gov/food/buy-store-serve-safe-food/raw-milk-misconceptions-and-danger-raw-milk-consumption (updated as of 3-5-2024, accessed 4-2-2025)

3. CDC. Food Safety – Raw Milk. https://www.cdc.gov/food-safety/foods/raw-milk.html (updated as of 1-31-2025, accessed 4-2-2025)

4. American Academy of Pediatrics Committee on Infectious Diseases, Committee on Nutrition. Consumption of Raw or Unpasteurized Milk and Milk Products by Pregnant Women and Children. Pediatrics January 2014; 133 (1): 175–179. 10.1542/peds.2013-

3502. Updated and reaffirmed November 2019.
https://publications.aap.org/pediatrics/article/133/1/175/68300/Consumption-of-Raw-or-Unpasteurized-Milk-andA-Milk

Background Information: Provided by AOA Staff
Current AOA Policy: 2009; 2014 Reaffirmed; 2019 Reaffirmed as Amended; 2020 Referred; 2024 Referred

Prior HOD action on similar or same topic:
H413-A/24 - Referred to Bureau of Research and Public Health

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ____July 19, 2025_____________

SUBJECT: BREAST IMPLANT ILLNESS (BII)
- SOURCE: REFERRED-H413-A/24

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, the Ohio Osteopathic Association submitted resolution H434-A2024
2 Recognizing Breast Implant Illness (BII) and Promoting Informed Consent for
3 Breast Implant Procedures; and

4 WHEREAS, resolution H434-A2024 was referred to the Bureau of Osteopathic
5 Research and Public Health (BORPH); and

6 WHEREAS, breast augmentation procedures involving the insertion of breast
7 implants have become increasingly common; and

8 WHEREAS, recent evidence has emerged regarding the risks associated with
9 breast implants, including the development of Breast Implant-Associated
10 Anaplastic Large Cell Lymphoma (BIA-ALCL) and systemic symptoms
11 collectively referred to as Breast Implant Illness (BIL); and

12 WHEREAS, a mechanistic link of bacterial biofilm–mediated host-pathogen
13 interaction has been found leading to immunological complications
14 associated with breast implant illness (BII); and

15 WHEREAS, the Food and Drug Administration (FDA) has issued a boxed warning
16 advising patients and health care professionals about the risks associated
17 with breast implants, including the potential for complications over time, the
18 increased likelihood of additional surgeries, the association with BIA-ALCL,
19 and the occurrence of systemic symptoms; and

20 WHEREAS, the AOA recognizes the importance of providing patients with
21 comprehensive information regarding the risks and benefits of breast
22 implants; now, therefore be it

23 RESOLVED, that the American Osteopathic Association (AOA) acknowledges that
24 a constellation of signs and symptoms may be associated with Breast
25 Implant Illness (BII); and be it further

26 RESOLVED, that the AOA encourages health care professionals to educate
27 patients about the potential risks associated with breast implants, including
28 developing Breast Implant-Associated Anaplastic Large Cell Lymphoma
29 (BIA-ALCL) and systemic symptoms, and the risks outlined in the Food and
30 Drug Administration (FDA) boxed warning and other labeling; and be it
31 further

RESOLVED, ~~that AOA supports efforts to educate patients on the risks associated with breast implants.~~**THAT THE AOA SUPPORT EFFORTS FOR CONTINUED RESEARCH TO THE LONG-TERM EFFECTS OF BREAST IMPLANTATION, INCLUDING RISK MITIGATION AND EARLY DETECTION OF COMPLICATIONS.**

References:

1. Cohen Tervaert JW, Mohazab N, Redmond D, van Eeden C, Osman M. Breast implant illness: scientific evidence of its existence. Expert Rev Clin Immunol. 2022 Jan;18(1):15-29. doi: 10.1080/1744666X.2022.2010546. Epub 2022 Jan 5. PMID: 34882509Suh LJ. https://pubmed.ncbi.nlm.nih.gov/34882509/

2. Khan I, Kelley-Patteson C, Mohan G, Hassanein AH, Sinha M. Breast Implant-Associated Immunological Disorders. J Immunol Res. 2022 May 4;2022:8536149. doi: 10.1155/2022/8536149. PMID: 35571560; PMCID: PMC9095406. https://pmc.ncbi.nlm.nih.gov/articles/PMC9095406/

3. https://www.fda.gov/medical-devices/implants-and-prosthetics/breast-implants .

4. Serena TJ, Habib P, Derosa A. Breast Implant Illness: A Cohort Study. Cureus. 2023 Apr 24;15(4):e38056. doi: 10.7759/cureus.38056. PMID: 37228535; PMCID: PMC10208020. https://pubmed.ncbi.nlm.nih.gov/37228535/

5. Magnusson MR, McGuire P. Commentary on: Understanding Breast Implant Illness: Etiology is the Key. Aesthet Surg J. 2022 Mar 15;42(4):378-380. doi:10.1093/asj/sjab191. PMID: 33864368. https://academic.oup.com/asj/article/42/4/378/6231987

6. Bascone CM, McGraw JR, Couto JA, Sulkar RS, Broach RB, Butler PD, Kovach SJ 3rd. Exploring Factors Associated with Implant Removal Satisfaction in Breast Implant Illness Patients: A PRO BREAST-Q Study. Plast Reconstr Surg Glob Open. 2023 Sep 25;11(9):e5273. doi: 10.1097/GOX.0000000000005273. PMID: 37753329; PMCID: PMC10519512. https://pubmed.ncbi.nlm.nih.gov/37753329/

7. Khan, I, et.al. Biofilm-derived oxylipin 10-HOME–mediated immune response in women with breast implants. J Clin Invest. 2024;134(3):e165644. https://doi.org/10.1172/JCI165644 .

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic:
H413-A/24 - Referred to Bureau of Research and Public Health

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: _____July 19, 2025________________

SUBJECT: REAFFIRMING COMMITMENT TO EVIDENCE-BASED PROTECTION AGAINST VACCINE-PREVENTABLE ILLNESSES

SUBMITTED BY: American College of Osteopathic Pediatricians

REFERRED TO: Committee on Public Affairs

WHEREAS, Jonas Salk developed the inactivated polio vaccine in the 1950s, resulting in a decrease of annual cases of 58,000 in 1957, to 161 in 1961, and eradication in 1994, ushering in an age of preventing deadly illness through vaccine efficacy in the United States; [1] and

WHEREAS, in the decade leading up to the vaccine, measles cases numbered more than three million per year in the U.S. with a drastic decline after the invention of the measles vaccine in 1963 and official eradication of measles from the U.S. in 2000, with just 47 cases in 2023 (2,3); and

~~WHEREAS, as a result of the 1989-1991 measles epidemic, Congress passed the Omnibus Budget Reconciliation Act of 1993 which formed the Vaccine for Children program which provided free access to vaccines to all eligible children less than 18 years old. To date this program has prevented more than 472 million illnesses, and 29.8 million hospitalizations; amounting to over $2.2 trillion in healthcare cost savings [4]; and~~

~~WHEREAS, per a Jan. 12, 2025, New York Times report, even prior to the current administration the percentage of kindergarteners entering with complete MMR vaccination had fallen from 95% to <93% which is equal to 280,000 children entering the classroom without protection from measles [5]; and~~

~~WHEREAS, the current Secretary of Health and Human Services (HHS) has a long history of using mis- and disinformation to promote debunked claims about the link between vaccines and neurodevelopmental outcome such as autism; and~~

WHEREAS, as of April 10, 2025, there have been 712 confirmed measles cases in the United States and 3 deaths, including 2 children, with 97% of these cases coming from individuals who are either unvaccinated or with an unknown vaccination status. This number already eclipses the 285 total cases reported for 2024 [6]; and **NOW THEREFORE BE IT**

~~WHEREAS, the U.S. is at risk of losing its status of having eradicated measles if this trend continues; now, therefore be it~~

30 RESOLVED, that the American Osteopathic Association (AOA) reaffirms its support
31 for evidence-based medicine regarding the safety and efficacy of
32 vaccinations; and be it further

33 RESOLVED, that the AOA supports continued public education on vaccine safety
34 and efficacy not limited to support of community efforts to distribute
35 information regarding the benefits of routine childhood vaccinations; and, be
36 it further

37 RESOLVED, that the AOA commits to combating vaccine mis- and disinformation
38 ~~including rejecting any literature or proclamations linking~~ **ABOUT** vaccines ~~to~~
39 ~~autism~~; and be it further

40 RESOLVED, that the AOA will actively oppose any and all legislation **AND**
41 **EXECUTIVE ORDERS** aimed at ~~utilizing debunked science to restrict~~
42 **RESTRICTING** the ongoing access to ~~free~~ routine vaccination as a means of
43 stopping the spread of preventable illness.

References:

1. World Health Organization. (n.d.). *History of polio vaccination*. https://www.who.int/news-room/spotlight/history-of-vaccination/history-of-polio-vaccination
2. Mayo Clinic. (n.d.). *Measles virus: Vaccine guidance from Mayo Clinic*. https://www.mayoclinic.org/diseases-conditions/history-disease-outbreaks-vaccine-timeline/measles
3. Centers for Disease Control and Prevention. (2023, December 21). *History of measles*. https://www.cdc.gov/measles/about/history.html
4. Centers for Disease Control and Prevention. (2023, October 6). *About the Vaccines for Children (VFC) program*. https://www.cdc.gov/vaccines/programs/vfc/about/index.html
5. Belluck, P. (2023, July 2). *Childhood vaccination rates were falling even before the rise of R.F.K. Jr. The New York Times.* https://www.nytimes.com/2023/07/02/health/vaccination-rates-decline-rfk-jr.html
6. Centers for Disease Control and Prevention. (2024, March 7). *Measles cases and outbreaks*. https://www.cdc.gov/measles/cases-outbreaks.html

Background Information: Provided by AOA Staff

Current AOA Policy:

H414-A/24	Vaccines
H402-A/20	Public Education Regarding the Importance and Safety of Vaccines for Infants, Children and Adults
H407-A/20	Vaccines for Children Program
H414-A/23	Immunizations
H403-A/20	Support for the Advisory Committee on Immunization Practices (ACIP) Recommendations

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ___Adopted as Amended_

DATE ________July 19, 2025____________

SUBJECT: CONTINUED SUPPORT OF ACCESS TO AND RESEARCH ON NATIONAL NEWBORN METABOLIC SCREENING PROTOCOLS

SUBMITTED BY: American College of Osteopathic Pediatricians

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, since its inception in 1960, newborn metabolic screenings have been a
2 vital component of public health in the United States to detect potential
3 serious conditions, as required by law[1]; and

4 WHEREAS, the Advisory Committee on Heritable Disorders in Newborns and
5 Children (ACHDNC) recommends that every screening panel for newborns
6 screen for 36 core conditions and an additional 26 secondary disorders put
7 forth by the Secretary of the U.S. Department of Health and Human Sciences
8 (HHS)[2]; and

9 WHEREAS, newborn screening programs are limited due to variation across
10 states[3,4,5]; currently only two state programs offer newborn screening panels
11 spanning all 36 conditions recommended on the Recommended Uniform
12 Screening Panel (RUSP) and only 27 screen for at least 35 conditions[6]; and

13 WHEREAS, researchers estimated savings of $2.4 million per 100,000 infants
14 screened over 60 years in spinal muscular atrophy alone[7]; and

15 WHEREAS, a study utilizing the National Survey of Children's Health determined
16 that between 2016-2017, 2.8 million children ages 0-17 years old have a
17 genetic condition emphasizing the need for effective screenings[8]; and

18 WHEREAS, a retrospective study conducted with 573 infants that died before the
19 age of one had determined that 22% of the infants had a laboratory-
20 confirmed genetic diagnosis, and 52% of those diagnosed were determined
21 postnatally[9]; and

22 WHEREAS, parents/guardians of children with a positive newborn screening test
23 reported less difficulty in receiving necessary specialist care as compared
24 with reports of parents/guardians of children with genetic conditions who
25 were diagnosed later[7]; and

26 WHEREAS, a 2020 study published in *Pediatrics*, stated that over 95% of subjects
27 in a long-term study of children identified with inborn errors of metabolism,
28 identified by Newborn Screenings, were successfully reaching age-
29 appropriate developmental milestones; and,

30 WHEREAS, the same 2020 study stated that without these screenings, the children
31 would have been susceptible to chronic neurologic dysfunction and
32 mortality[10]; and

33 WHEREAS, a 2021 article also published in *Pediatrics* collected evidence that early
34 diagnosis through screening prevented severe malnutrition and improved
35 long term growth in infants diagnosed with cystic fibrosis, has proved
36 newborn screening's utility in the interest of public health[11]; and

37 WHEREAS, while guidance has historically been put forth by the U.S. Secretary of
38 HHS through the Recommended Uniform Screening Panel (RUSP), states
39 still create and regulate their own screening policies which results in a lack of
40 procedural standardization[1,12]; and

41 WHEREAS, as of a March 27, 2025, statement from the HHS announcing the
42 consolidation of the Health Resources and Services Administration (HRSA)
43 into the new Administration for a Healthy America (AHA)[13] which has led to
44 the functional dissolution of both the ACHDNC and RUSP, leaving the
45 newborn screening program without a source of guidance or funding, now
46 therefore be it;

47 ~~RESOLVED, that the American Osteopathic Association (AOA) commits to joining~~
48 ~~any advocacy efforts for the immediate reinstatement of the ACHDNC and~~
49 ~~RUSP; and, be it further~~

50 **RESOLVED, THAT THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA)**
51 **SUPPORTS EFFORTS TO CREATE CLINICAL GUIDELINES THAT**
52 **DESCRIBE EVIDENCE BASED RECOMMENDED UNIFORM SCREENING**
53 **OF NEWBORNS, EITHER THROUGH THE REINSTATEMENT OF AN**
54 **ADVISORY COMMITTEE UNDER HEALTH AND HUMAN SERVICES**
55 **(HHS) TO ISSUE GUIDANCE OF HERITABLE DISORDERS IN**
56 **NEWBORNS AND CHILDREN AND A RECOMMENDED UNIFORM**
57 **SCREENING PANEL, OR THE DEVELOPMENT OF EVIDENCE BASED**
58 **GUIDELINES BY PHYSICIAN ORGANIZATIONS.**
59

60 RESOLVED, that the AOA supports an increase in research on the improved
61 benefit of ~~interstate~~ standardization of screening protocols and their role in
62 early diagnosis and treatment of newborn illnesses; and, be it further

63 RESOLVED, that the AOA encourages osteopathic physicians to increase
64 accessibility to expecting parents on educational resources that address
65 disparities around screening protocols, conditions available for screening,
66 and how prompt identification and treatment of these disorders may lead to
67 more favorable outcomes

References:

1. *About newborn screening*. About Newborn Screening | Newborn Screening.

(2023, June). https://newbornscreening.hrsa.gov/about-newborn-screening
2. Health Resources and Services Administration. (2023, August). *Advisory Committee on Heritable Disorders in newborns and children*. Advisory Committee on Heritable Disorders in Newborns and Children. https://www.hrsa.gov/advisory-committees/heritable-disorders#:~:text=The%20Committe e%20recommends%20that%20every
3. Speiser, P., Chawla, R., Chen, M., Diaz-Thomas, A., Finlayson, C., Rutter, M., Sandberg, D., Shimy, K., Talib, R., Cerise, J., Vilain, E., & Délot, E. (2020). Newborn screening protocols and positive predictive value for congenital adrenal hyperplasia vary across the United States. *International Journal of Neonatal Screening*, *6*(2), 37. https://doi.org/10.3390/ijns6020037
4. Gaviglio, A., McKasson, S., Singh, S., & Ojodu, J. (2023, April 13). *Infants with congenital diseases identified through newborn screening-United States, 2018–2020*. MDPI. https://www.mdpi.com/2409-515X/9/2/23
5. *Newborn Screening in Your State*. About Newborn Screening | Newborn Screening. (2023, December). https://newbornscreening.hrsa.gov/your-statehttps://newbornscreening.hrsa.gov/your-stat e
6. Singh, S., Ojodu, J., Kemper, A. R., Lam, W. K., & Grosse, S. D. (2023). Implementation of newborn screening for conditions in the United States first recommended during 2010–2018. *International Journal of Neonatal Screening*, *9*(2), 20. https://doi.org/10.3390/ijns9020020
7. Wojcik, M. H., Schwartz, T. S., Thiele, K. E., Paterson, H., Stadelmaier, R., Mullen, T. E., VanNoy, G. E., Genetti, C. A., Madden, J. A., Gubbels, C. S., Yu, T. W., Tan, W.-H., & Agrawal, P. B. (2019). Infant mortality: The contribution of genetic disorders. *Journal of Perinatology*, *39*(12), 1611–1619. https://doi.org/10.1038/s41372-019-0451-5
8. Lichstein, J., Riley, C., Keehn, A., Lyon, M., Maiese, D., Sarkar, D., & Scott, J. (2021). Children with genetic conditions in the United States: Prevalence estimates from the 2016-2017 National Survey of Children's Health. Genetics in Medicine, 24(1).
9. Hopkins, P. V., Klug, T., Vermette, L., Raburn-Miller, J., Kiesling, J., & Rogers, S. (2018). Incidence of 4 lysosomal storage disorders from 4 years of newborn screening. *JAMA Pediatrics*, *172*(7), 696. https://doi.org/10.1001/jamapediatrics.2018.0263
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Background Information: Provided by AOA Staff
Current AOA Policy: H-319 - A/24 Newborn HIV Testing,
H625 - A/20 Newborn and Infant Hearing Screens

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN __Adopted as Amended__

DATE ______July 19, 2025_____________

SUBJECT: EQUITABLE USE AND COVERAGE OF ANTI-OBESITY INCRETIN MIMETIC MEDICATIONS

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Committee on Public Affairs

WHEREAS, obesity is a complex, chronic disease influenced by genetic, environmental, physical, and emotional factors, necessitating a multimodal treatment approach including pharmacotherapy, lifestyle, and behavioral modifications[1,2]; and

WHEREAS, incretin-mimetic medications such as glucagon like peptide-1 receptor agonists (GLP-1 RAs) and gastric inhibitory polypeptides (GIPs) have been shown to be effective in reducing body weight, appetite, food cravings, and energy intake while increasing satiety and improving eating control[3,4,5,6,7]; and

WHEREAS, the current access to these incretin-mimetic medication for obesity management remains limited due to high costs and insurance coverage restrictions, creating significant barriers for patients who could benefit from their use[8,9,10]; and

WHEREAS, GLP-1 RAs and GIP therapeutics ~~are~~ **IN SELECTED CASES MAY BE** more effective compared to the alternative anti-obesity medications, such as phentermine-topiramate and naltrexone-bupropion, which have demonstrated efficacy but are associated with significant negative side effects[11,12]; and

WHEREAS, the economic burden of obesity is estimated at $260.6 billion annually in the United States, and improved access to effective pharmacotherapy may reduce long-term healthcare costs by mitigating obesity-related comorbidities[13]; and

WHEREAS, research suggests that the cost-effectiveness of covering pharmacotherapy for obesity may outweigh the long-term financial burden of untreated obesity and its associated comorbidities[14,15]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports policies that reduce financial barriers for patients seeking access to incretin-mimetic medications, while promoting transparency and flexibility within insurance plans to allow for diverse treatment options; and, be it further

1 RESOLVED, the AOA supports continued research, education, and advocacy to
2 expand awareness and appropriate utilization of pharmacotherapy within the
3 context of multimodal obesity care.

References:

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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: July 19, 2025

SUBJECT: ADVOCATE FOR ACCESS TO OVERWEIGHT AND OBESITY CARE

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, Per the Centers for Disease Control (CDC), from August 2021 to August 2023, the prevalence of obesity among adults in the United States was 40.3%, which remains above the Healthy People 2030 goal of 36.0%;[1]

WHEREAS, In June 2013, the American Medical Association (AMA) House of Delegates voted to recognize obesity as a disease state requiring treatment and prevention efforts;[2]

WHEREAS, the majority of insurance providers continue to exclude reimbursement for weight management visits, as well as coverage of ~~Federal~~ **FOOD AND** Drug **ADMINISTRATION** ~~Agency~~ (FDA) approved medications for treatment of patients with overweight and/or obesity;[3] now, therefore be it:

RESOLVED, that the American Osteopathic Association (AOA) recognize obesity as a complex, multifactorial disease, an interaction between genotype and environment, which has socioeconomic, behavioral, cultural, physiological, metabolic, and genetic factors; and be it further

RESOLVED, that the AOA advocate for payment ~~for medical services and procedures~~ **OF MEDICAL SERVICES, PROCEDURES, AND FDA-APPROVED MEDICATIONS** used to treat and manage patient's weight with or without associated weight related conditions; and be it further

RESOLVED, that the AOA advocate for insurance coverage of FDA approved medications used to treat patients with overweight and/or obesity~~; and be it further~~

~~RESOLVED, that this resolution be sent to the AOA for consideration by the 2025 AOA House of Delegates.~~

References:

[1]Emmerich SD, Fryar CD, Stierman B, Ogden CL. Obesity and severe obesity prevalence in adults: United States, August 2021–August 2023. NCHS Data Brief, no 508. Hyattsville, MD: National Center for Health Statistics. 2024. DOI: https://dx.doi.org/10.15620/cdc/159281
[2]Kyle TK, Dhurandhar EJ, Allison DB. Regarding Obesity as a Disease: Evolving Policies and Their Implications. Endocrinol Metab Clin North Am. 2016

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Background Information: Provided by AOA Staff
Current AOA Policy:
H322-A/23 Obesity – Health Plans should include Benefits for Treatment of
H408-A/22 Prevention and Treatment of Obesity
H421-A/23 Pediatric Obesity

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: AGAINST THE USE OF FOOD DYES AND PRESERVATIVES

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Public Affairs

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1 WHEREAS**,** synthetic food dyes such as Red 40, Yellow 5, and Blue 1 are widely used
2 in food products despite studies linking them to hyperactivity, allergic reactions,
3 and potential carcinogenic effects; and
4
5 WHEREAS**,** research published in the *International Journal of Occupational Medicine*
6 *and Environmental Health* has associated prolonged exposure to artificial food
7 dyes with increased oxidative stress and DNA damage (1); and
8
9 WHEREAS**,** preservatives such as sodium benzoate, butylated hydroxyanisole (BHA),
10 and butylated hydroxytoluene (BHT) have been shown to disrupt endocrine
11 function and increase the risk of chronic illnesses, including cancer and
12 metabolic disorders; (2, 3) and
13
14 WHEREAS, the European Union has placed restrictions or labeling requirements on
15 certain food dyes and preservatives due to health concerns, providing a
16 regulatory model that prioritizes consumer safety (4); and
17
18 WHEREAS**,** educating patients and advocating for stricter regulations can help reduce
19 exposure to potentially harmful additives, thereby improving public health; and,
20 now therefore be it:
21
22 RESOLVED**,** the American Osteopathic Association (AOA) opposes the use in food
23 products of synthetic dyes and preservatives that have known harmful effects
24 and advocates for increased research and regulation on their safety; and be it
25 further
26
27 RESOLVED**,** that a copy of this resolution be submitted to the AOA for consideration at
28 the 2025 AOA House of Delegates.
29

References:

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6) Synthetic Colors in Food: A warning for Children's Health Int Journal of Envir. Resarch and Public Health 2024 PMID 38928929

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: ________July 19, 2025__________

SUBJECT: **ACCESS TO MENSTRUAL HEALTH PRODUCTS**~~RECOGNIZING PERIOD POVERTY AS A POLICY CONCERN~~

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, "Period poverty" is defined as a lack of access to and an inability to afford menstrual hygiene products (MHPs)[1] often leading to physical, mental, emotional, and social challenges[2]; and

WHEREAS, 16.9 million individuals who menstruate in the United States live in poverty[2]; and

WHEREAS**,** lack of access and ability to afford menstrual products leads to harmful menstrual hygiene practices such as using non-sanitary menstrual product alternatives, using ill-fitting products, and wearing products for longer than safely intended, leading to the potential for development of infection of chafed skin, toxic shock syndrome, and disrupted vaginal flora[3]; and

WHEREAS, the average menstruating American spends $18,000 across their menstruating lifetime on MHPs[4], with that estimate likely being higher in individuals who experience menorrhagia (heavy menstrual bleeding); and

~~WHEREAS, 40% of Americans have admitted to struggling at one point in their life to afford MHPs[5]; and~~

WHEREAS, policy and advocacy addressing period poverty, in public schools has been shown to have positive effects on education, such as on test scores and attendance rates [6]; and

WHEREAS, efforts by states to remove the sales tax from MHPs has been shown to improve access to these items[7,8,9]; and

WHEREAS, the American Osteopathic Association (AOA) is dedicated to protecting patient access to care through federal, state, and profession wide advocacy[10]; now, therefore be it

RESOLVED, ~~that the American Osteopathic Association (AOA) supports local, state, and federal efforts that promote menstrual health equity.~~**THAT THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) SUPPORTS EFFORTS ON LOCAL, STATE, AND NATIONAL LEVELS TO EXPAND ACCESS TO AFFORDABLE OR FREE MENSTRUAL HYGIENE PRODUCTS FOR INDIVIDUALS EXPERIENCING PERIOD POVERTY,**

31 **SUPPORTS THE REMOVAL OF SALES TAX ON MENSTRUAL**
32 **PRODUCTS, ENCOURAGES PUBLIC HEALTH EDUCATION ON SAFE**
33 **MENSTRUAL HYGIENE PRACTICES, AND ENCOURAGES MEMBERS**
34 **AND PARTNER ORGANIZATIONS TO COLLABORATE WITH**
35 **COMMUNITY ORGANIZATIONS AND EDUCATIONAL INSTITUTIONS**
36 **TO REDUCE THE COMMUNITY ORGANIZATIONS AND**
37 **EDUCATIONAL INSTITUTIONS TO REDUCE THE COMMUNITY**
38 **ORGANIZATIONS AND EDUCATIONAL INSTITUTIONS TO REDUCE**
39 **THE STIGMA AROUND PERIOD POVERTY TO IMPROVE**
40 **MENSTRUAL HEALTH OUTCOMES.**

References:

1. Thinx, Inc. and PERIOD. (2023, October). State of the Period 2023. PERIOD. https://period.org/uploads/SOTP-2023.pdf
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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: ____July 20, 2025__

SUBJECT: SHARING CENTRALIZED RESOURCES ON STATE-SPECIFIC REPRODUCTIVE HEALTH POLICIES

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, federal changes limiting access to reproductive health information on federal health websites have left physicians and patients unaware of reproductive rights on a national scale[1]; and

WHEREAS, variations in access to comprehensive reproductive health care exist across states and are constantly changing; for example, Mississippi prohibits pregnancy termination once a fetal heartbeat is detected and Alabama criminalizes pregnancy termination unless the mother’s life is threatened- highlighting the need for centralized guidance[2]; and

WHEREAS, the lack of clarity and uncertain enforcement of state reproductive health laws by regulatory agencies creates a challenging landscape for physicians to navigate[3]; and

WHEREAS, without clear guidance from the profession, physicians practicing in states with restrictive reproductive health laws are hesitant to refer patients out of state for legal pregnancy termination or provide patients with online resources about pregnancy termination - that not only impacts patient access to reliable health information and care, but it also negatively affects the patient-physician relationship [4,5]; and

WHEREAS, tools, such as the Guttmacher Interactive Map[7] and the Kaiser Family Foundation’s State Profiles for Women’s Health[8], showing reproductive health care access across various states are available but should be shared within medical communities to raise awareness and provide centralized access to reliable, evidence-based information; and

WHEREAS, the American Osteopathic Association (AOA) is committed to protecting the sanctity of the patient-physician relationship from interference laws[9,10] and recognizes the importance of having access to federal health data and guidance[11]; and now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) **MAKES AVAILABLE EXISTING** ~~shares~~ evidence-based, validated tools **WITHIN THE OSTEOPATHIC PHYSICIAN COMMUNITY** to improve physician access to **ACCURATE** reproductive health information.

References:

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3. J. Kelly (2022). Statement on state laws impacting patient access to necessary medicine. American Medical Association. Statement on state laws impacting patient access to necessary medicine | American Medical Association
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9. American Osteopathic Association. (2022, June 26). AOA statement on Supreme Court repeal of Roe v. Wade. [Press release]. https://osteopathic.org/2022/06/26/statement-on-the-supreme-court-repealing-roe-v-wade/
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Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $150,000 Annually

The fiscal impact is due to staff resources to oversee the website content as information is consistently changing based on frequently changing laws, frequent guideline updates and monitoring of legal cases.

Staff resources to ensure the materials posted on the AOA website as up to date will consist of researching and vetting the information and making updates when appropriate.

ACTION TAKEN: ___Referred to the AOA Finance Committee____

DATE: ______July 20, 2025___________

SUBJECT: FAMILY PLANNING AND FERTILITY PRESERVATION RESOURCES FOR MEDICAL TRAINEES

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, medical training is rigorous, spanning between 7 to 15 years, leading physician~~s~~ and trainees **FAMILIES & PARTNERSHIPS** to delay childbearing until the completion of ~~their~~ **THIS** training[1]; and

WHEREAS, this delay for training amongst female**S** ~~physicians~~ is associated with higher risk pregnancies [1,2,3]; and

WHEREAS, less than half of medical students receive education on **REPRODUCTIVE HEALTH** fertility, fertility preservation, age-related decline, in vitro fertilization (IVF), and oocyte cryopreservation[4,5]; and

WHEREAS, a study of female medical students, residents, and attendings showed an average score of 69% on the Fertility and Infertility Treatment Knowledge Score (FIT-KS), highlighting the systematic knowledge gap of infertility during medical education[6]; and

WHEREAS, a common barrier to family building for medical students and residents is the stigma associated with having children while actively in training [7,8]; and

WHEREAS, the American Osteopathic Association is dedicated to supporting and providing resources for all osteopathic medical students' careers and wellbeing[7]; now, therefore be it

RESOLVED, THAT THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) SUPPORTS OSTEOPATHIC MEDICAL TRAINEES IN BUILDING HOLISTIC FUTURES - BOTH PERSONAL AND PROFESSIONAL - BY PROMOTING THE PROVISION OF FAMILY PLANNING AND REPRODUCTIVE HEALTH FERTILITY GUIDANCE; AND, BE IT FURTHER

RESOLVED, that ~~the American Osteopathic Association (~~AOA~~)~~ encourage**S** already established resources~~, such as *The DO* articles~~ or mentorship opportunities~~, to encompass discussions~~ surrounding family planning and **REPRODUCTIVE HEALTH** fertility ~~preservation~~ throughout medical training**.**~~; and, be it further~~

30 ~~RESOLVED, that the AOA collaborates with its affiliates to promote the provision~~
31 ~~of family planning and fertility preservation resources to trainees~~
32 ~~throughout medical training.~~

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8. Stack, S. W., Jagsi, R., Biermann, J. S., Lundberg, G. P., Law, K. L., Milne, C. K., Williams, S. G., Burton, T. C., Larison, C. L., & Best, J. A. (2020). Childbearing decisions in residency: A multicenter survey of female residents. *Academic Medicine*, *95*(10), 1550–1557. https://doi.org/10.1097/acm.0000000000003549
9. "Student Doctors." American Osteopathic Association, 9 Feb. 2024, osteopathic.org/students/

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

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $3,000
The fiscal impact is for staff time to collect and distribute resources.

ACTION TAKEN: _Adopted as Amended_____

DATE: ___July 20, 2025__________

SUBJECT: RETAIL MEDICAL CLINICS IN FACILITIES SELLING TOBACCO, NICOTINE OR VAPING PRODUCTS - SOURCE H-309/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Committee on Public Affairs

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) discourages the placement of
7 medical practices and limited service clinics in retail settings that promote and sell
8 tobacco because it is contrary to the efforts and standards of the health care
9 community at large.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Not Adopted_

DATE: _______July 19, 2025______

AMERICAN OSTEOPATHIC ASSOCIATION

500 Series Constitution and Bylaws Resolutions

Actions

AMERICAN
OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
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312.202.8000

osteopathic.org

105th ANNUAL AOA HOUSE OF DELEGATES MEETING
2025 RESOLUTION ROSTER (500 SERIES)
As of 07-19-25

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
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	Reference Committee	Action
H-500	Amendments to the American Osteopathic Association Bylaws – Article VII	CAGOS	Constitution & Bylaws	Adopted as Amended

SUBJECT: AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION BYLAWS – ARTICLE VII

SUBMITTED BY: Committee on AOA Governance and Organizational Structure (CAGOS)

REFERRED TO: Committee on Constitution and Bylaws

WHEREAS, there is an editorial amendment to Editor-in-Chief in AOA Bylaw Article VII Board of Trustees – Section 1 (b) – to delete “-in-Chief” and the title be “Editor” to be consistent with the AOA Constitution; now therefore be it

RESOLVED, that the AOA House of Delegates approve the following amendments to:

AOA Bylaws

Article VII - Board of Trustees

Section 1-Duties The Board of Trustees shall:

b. Appoint a Chief Executive Officer, a Chief Financial Officer, a General Counsel, and ~~the~~ **AN** Editor~~-in-Chief~~ and shall fix the amount of their salaries and the length of their terms of office. It shall fix the duties of the Chief Executive Officer, Chief Financial Officer, General Counsel, ~~the~~ Editor~~-in-Chief~~ and all other officials, committees, departments and bureaus necessary to the proper execution of the policies of the Association and not fixed by these Bylaws.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above.

Prior HOD action on similar or same topic:
None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

AMERICAN OSTEOPATHIC ASSOCIATION

600 Series
Ad Hoc
Resolutions

Actions

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105th ANNUAL AOA HOUSE OF DELEGATES MEETING
2025 RESOLUTION ROSTER (600 SERIES)
As of 07-19-25

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
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	Reference Committee	Action
H-600	Encouraging Patient Participation in their Health Care (SR-Source-H609-A/20)	BFHP	Ad Hoc	Adopted
H-601	Veterans Administration Credentialing of Non-Physician Providers Health Records (SR-Source-H621-A/20)	BFHP	Ad Hoc	Adopted as Amended
H-602	Tax Credits for Health Profession Shortage Areas (SR-Source-H622-A/20)	BFHP	Ad Hoc	Adopted
H-603	Prescription of Drugs for off Label Uses (SR-Source-H624-A/20)	BFHP	Ad Hoc	Adopted as Amended
H-604	Preventive Medical Screening (SR-Source-H626-A/20)	BFHP	Ad Hoc	Adopted as Amended
H-605	Medical Procedure Patents (SR-Source-H632-A/20)	BFHP	Ad Hoc	Adopted
H-606	Support the bolstering of Veteran Administration Resources through Provider Pay Reform (SR-Source-H649-A/20)	BFHP	Ad Hoc	Adopted as Amended
H-607	Physician Competency Retesting (SR-Source-H607-A/20)	BOE	Ad Hoc	Adopted as Amended
H-608	Diabetics Confined to Correctional Institutions (SR-Source-H628-A/20)	BORPH	Ad Hoc	Adopted as Amended
H-609	Postpartum Depression (SR-Source-H646-A/20)	BORPH	Ad Hoc	Adopted
H-610	Researching Patient Safety and Provider Qualifications (SR-Source-H648-A/20)	BORPH	Ad Hoc	Adopted as Amended
H-611	Dissemination of Publications in Osteopathic Research (SR-Source-H600-A/20)	BORPH	Ad Hoc	Adopted as Amended
H-612	Proper Badge Identification of Employees in a Hospital Setting (SR-Source-H604-A/20)	BORPH	Ad Hoc	Adopted as Amended
H-613	Health Plan Coverage of Tobacco Cessation Treatment (SR-Source-H608-A/20)	BORPH	Ad Hoc	Adopted as Amended
H-614	Newborn and Infant Hearing Screens (SR-Source-H625-A/20)	BORPH	Ad Hoc	Adopted

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105th ANNUAL AOA HOUSE OF DELEGATES MEETING
2025 RESOLUTION ROSTER (600 SERIES)
As of 07-19-25

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-615	Pediatric Psychiatric Care ~~Health Records~~ (SR-Source-H617-A/20)	CERA	Ad Hoc	Adopted as Amended
H-616	Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder (SR-Source-H-618-A/20)	CERA	Ad Hoc	Adopted as Amended
H-617	Prior Authorization (SR-Source-H642-A/20)	CERA	Ad Hoc	Adopted as Amended
H-618	Managed Care Plans – Service, Access and Costs in – (SR-Source H647-A/20)	CERA	Ad Hoc	Adopted
H-619	~~Interoperability of~~ Health Information Technology **AND CLINICAL SOFTWARE: INTEROPERABILITY, SAFETY, AND RELIABILITY** (SR-Source-H605-A/20)	CERA	Ad Hoc	Adopted as Amended
H-620	Electronic Health Records – Physician Assistance Programs for Transition to (SR-Source-H615-A/20)	CERA	Ad Hoc	Adopted as Amended
H-621	Provider Tax (SR-Source-H611-A/20)	CSHA	Ad Hoc	Adopted
H-622	Medicaid Payment (SR-Source-H612-A/20)	CSHA	Ad Hoc	Referred to CSHA
H-623	Lay Midwives (SR-Source-H613-A/20)	CSHA	Ad Hoc	Adopted as Amended
H-624	Managed Care – All Products Clauses (SR-Source-H631-A/20)	CSHA	Ad Hoc	Adopted as Amended
H-625	Non-Physician Clinicians (SR-Source-H640-A20)	CSHA	Ad Hoc	Adopted
H-626	Osteopathic Manipulative Treatment (OMT) Coverage Determination Guidance (SR-Source H635-A/20; Referred H633-A/24)	BFHP	Ad Hoc	Adopted as Amended
H-627	Gifts to Physicians from Industry (SR-Source-H606-A/20)	Ethics	Ad Hoc	Adopted
H-628	Confidentiality of Patient Records (SR-Source-H627-A/20)	Ethics	Ad Hoc	Adopted
H-629	Executions in Capital Crimes Criminal Cases (SR-Source-H630-A/20)	Ethics	Ad Hoc	Adopted
H-630	A Proclamation Regarding the Inaccurate Portrayals of U.S. Trained DOs in the Media (SR-Source-H651-A/20)	Ethics	Ad Hoc	Adopted
H-631	Preventing the Criminal Prosecution of Medical Decision Making	MOA (Maine)	Ad Hoc	Adopted as Amended

105th ANNUAL AOA HOUSE OF DELEGATES MEETING
2025 RESOLUTION ROSTER (600 SERIES)
As of 07-19-25

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-632	Withdrawn	BEL		
H-633	Protecting Patient Care: Opposing the Growing Impact of Private Equity and the Corporate Practice of Medicine	BEL	Ad Hoc	Adopted as Amended
H-634	~~Federal~~ Loan Availability for Osteopathic Medical Students	NYSOMS (New York)	Ad Hoc	Adopted as Amended

SUBJECT: ENCOURAGING PATIENT PARTICIPATION IN THEIR HEALTH CARE - SOURCE: H609-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) recommends that all insurance
8 companies consider the establishment of a system for rewarding those patients who
9 are trying to stay healthy as a means of decreasing the amount of money spent on
10 health care.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ______Adopted_____

DATE: ________July 19, 2025________

SUBJECT: VETERANS ADMINISTRATION CREDENTIALING OF NON-PHYSICIAN PROVIDERS ~~HEALTH RECORDS~~
- SOURCE: H621-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Ad Hoc

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports the establishment of well-
8 defined credentialing and privileging criteria within the Veterans Administration (VA)
9 that prohibits non-physician providers **IN STATES** with expanded scope of practice
10 rights ~~in a minority of states~~ from demanding such privileges in the VA system and
11 supports the establishment of a consistent requirement for the privileging of non-
12 physician ~~providers~~ **CLINICIANS** in the VA system.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: _____July 19, 2025____________

SUBJECT: TAX CREDITS FOR HEALTH PROFESSION SHORTAGE AREAS - SOURCE: H622-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports the establishment of tax
8 credits for physicians who practice full time in federally designated health
9 professions shortage areas (HPSAs) or Medicare defined physician scarcity areas
10 and federally and/or state designated underserved areas and urges that these tax
11 credits be available, on a sliding scale, to physicians who provide services on a
12 part-time basis in these communities.

Background Information: Provided by AOA Staff
Current AOA Policy: 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_______

DATE: ____July 19, 2025___________

SUBJECT: PRESCRIPTION OF DRUGS FOR OFF LABEL USES - SOURCE: H624-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 **IT IS THE POSITION OF** the American Osteopathic Association (AOA) ~~believes it is~~
8 **THAT IT IS** appropriate for physicians to prescribe approved drugs for uses not
9 included in their official ~~labeling~~ **INDICATION** when they can be supported as
10 accepted medical practice.

Background Information: Provided by AOA Staff
Current AOA Policy: 1995; 2000 Reaffirmed; 2005; 2010; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: PREVENTIVE MEDICAL **SERVICES - MEDICARE** ~~SCREENING~~ - SOURCE: H626-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) ~~supports coverage of Medicare~~
8 ~~recipients for routine preventive medical services~~**COVERAGE OF ROUTINE**
9 **PREVENTIVE MEDICAL SERVICES FOR MEDICARE RECIPIENTS**.

Background Information: Provided by AOA Staff
Current AOA Policy: 1995; 2000 Reaffirmed, 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: MEDICAL PROCEDURE PATENTS - SOURCE: H632-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) supports measures that restrict
8 medical procedure patents.

Background Information: Provided by AOA Staff
Current AOA Policy: 1995; 2000 Reaffirmed, 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: SUPPORT THE BOLSTERING OF VETERAN ADMINISTRATION RESOURCES THROUGH ~~PROVIDER~~ **PHYSICIAN** PAY REFORM - SOURCE: H649-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau on Federal Health Programs has reviewed the policy; and

3 WHEREAS, the Bureau on Federal Health Programs believes that the policy
4 remains relevant now, therefore be it

5 RESOLVED, that the Bureau on Federal Health Programs recommends the
6 following policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) support both staffing management
8 and competitive pay reform at the Veterans' Health Administration (VHA) to ensure
9 that a full, stable workforces, as budgeted by the Department of Veterans Affairs, is
10 available to meet the health needs of the United States veteran population.

Background Information: Provided by AOA Staff
Current AOA Policy: 2020

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: PHYSICIAN COMPETENCY RETESTING - SOURCE: H607-A/20

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Education has reviewed the policy and
3 determined that it remains relevant; now, therefore be it

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

6 The American Osteopathic Association (AOA):

7 (1) Supports the mission of physician competency, ~~the~~ **DELIVERY OF HIGH**
8 **QUALITY CARE,** quality **IMPROVEMENT**~~movement~~ and patient safety
9 through self-regulation mechanisms rather than through government
10 mandated retesting for purposes of obtaining re-licensure or for receiving
11 payment under a health benefits program.

12 (2) Continue its voluntary efforts to address and promote physician
13 competency through the teaching of core competencies at the predoctoral
14 and postdoctoral levels, **AND** physician assessment through osteopathic
15 continuous certification.

Background Information: Provided by AOA Staff
Current AOA Policy: 1991, 1994 Revised, 1999, 2003; 2008; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic:
H329-A/24 Uniform Pathway of Licensing of Osteopathic Physicians
H213-A/22 Osteopathic Licensing

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 19, 2025__________

SUBJECT: DIABETICS CONFINED TO CORRECTIONAL INSTITUTIONS - SOURCE: H-628/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports the availability of American
7 Diabetes Association (ADA) diabetic meals, beverages, and other diabetic
8 interventions that follow ADA guidelines for all imprisoned persons with diabetes
9 who are under the care of a licensed physician and confined ~~in~~ **TO** correctional
10 institutions.

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: July 19, 2025

SUBJECT: POSTPARTUM DEPRESSION - SOURCE: H-646/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) encourages its members to
7 participate in continuing medical education programs on postpartum depression
8 (PPD); urges colleges of osteopathic medicine (COMs) and osteopathic state and
9 specialty associations to offer CME on PPD as part of their educational offerings;
10 and endorses the use of screening tools and encourage the measurement of
11 outcomes in their use.

Background Information: Provided by AOA Staff
Current AOA Policy: 2003; 2008; 2013 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted

DATE: July 19, 2025

SUBJECT: RESEARCHING PATIENT SAFETY AND ~~PROVIDER~~ **CLINICIAN** QUALIFICATIONS - SOURCE: H648/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed the policy; and

WHEREAS, the Bureau of Osteopathic Research and Public Health has provided amendments to provide clarity and updates to the policy, now therefore be it

RESOLVED, that the Bureau of Osteopathic Research and Public Health recommends that the following policy be REAFFIRMED AS AMENDED.

RESEARCHING PATIENT SAFETY AND PROVIDER QUALIFICATIONS

<u>REVIEW OF RESEARCH</u>

A REVIEW OF THE LITERATURE INDICATES VERY LITTLE RESEARCH INTO THE LACK OF QUALIFICATIONS OF NURSE PRACTITIONERS (NPS) AND PHYSICIAN ASSISTANTS (PAS) TO INDEPENDENTLY PROVIDE MEDICAL CARE. A 2022 AMERICAN MEDICAL ASSOCIATION (AMA) ISSUE BRIEF, ENTITLED *SUMMARY OF EXISTING STUDIES: SCOPE OF PRACTICE*, PROVIDES A SUMMARY OF 15 RESEARCH PROJECTS ON TOPICS INCLUDING COST AND QUALITY OF CARE, EDUCATION AND TRAINING, AND WORKFORCE STUDIES.[1]

IN JULY 2024, AN ARTICLE PUBLISHED BY BLOOMBERG NEWS, ENTITLED *THE MISEDUCATION OF AMERICA'S NURSE PRACTITIONERS*, ANALYZED THE SHORTCOMINGS IN NURSE PRACTITIONER EDUCATION AND TRAINING AND ITS IMPACT ON PATIENT CARE.[2]

THERE ARE MANY CHALLENGES TO CONDUCTING THE RESEARCH CALLED FOR IN THE RESOLUTION. THESE INCLUDE LACK OF FUNDING FOR COMPREHENSIVE LONGITUDINAL RESEARCH INTO NP AND PA OUTCOMES AND COST DATA. OTHER CHALLENGES INCLUDE LACK OF ACCESS TO MALPRACTICE CLAIMS DATA AND THE IMPRACTICALITY OF IDENTIFYING NPS AND PAS WHO MAY HAVE MISSED OR MISDIAGNOSED A PATIENT WHO LATER ENDS UP BEING SEEN BY A PHYSICIAN ONCE THEIR CONDITION WORSENS.

31 **SCOPE OF PRACTICE**

32 **SCOPE OF PRACTICE IS AN AOA PRIORITY ISSUE, AND THE PUBLIC POLICY**
33 **DEPARTMENT ACTIVELY ADVOCATES AGAINST INAPPROPRIATE SCOPE**
34 **EXPANSION ATTEMPTS BY NON-PHYSICIAN CLINICIANS. INFORMATION**
35 **REGARDING THE AOA'S ADVOCACY EFFORTS ON ALL PRIORITY ISSUES –**
36 **INCLUDING SCOPE OF PRACTICE – IS PROVIDED TO PHYSICIANS VIA THE**
37 **FOLLOWING COMMUNICATION CHANNELS:**

38 - **THE OSTEOPATHIC ADVOCACY NETWORK**
39 - **THE DO ENGAGE**
40 - **THE AOA DOCUMENT REPOSITORY (CONTAINS ALL LETTERS WRITTEN ON**
41 **PRIORITY ISSUES, SEARCHABLE BY KEYWORD)**
42 - **QUORUM SOFTWARE FOR REAL-TIME TRACKING OF PUBLIC POLICY**
43 **ACTIVITY ON VARIOUS ISSUES**

44

45 **SHOULD ADDITIONAL RESEARCH INTO NP AND PA COST AND QUALITY**
46 **OUTCOMES BECOME AVAILABLE, STAFF WILL INVESTIGATE THE PROPER**
47 **COMMUNICATIONS CHANNELS THROUGH WHICH TO DISSEMINATE IT.**

48

49 **AOA POLICY STATEMENT**

50

51 The American Osteopathic Association (AOA) encourages independent research on the
52 qualification**S** and outcomes of nurse practitioners, **PHYSICIAN ASSISTANTS**, and other
53 midlevel providers that practice independently~~; and that the AOA research & public health~~
54 ~~staff perform an analysis of current, valid and published research~~ **FOCUSING**
55 **SPECIFICALLY** on clinical outcomes, resource utilization and malpractice experience for
56 independently practicing NPs and PAs, ~~**PROVIDING THIS INFORMATION**~~ **AND SHARE**
57 **AS IT BECOMES AVAILABLE THROUGH OSTEOPATHIC ADVOCACY NETWORK**
58 **COMMUNICATION CHANNELS OR OTHER VENUES, AS APPROPRIATE.** ~~and provide~~
59 ~~this information to osteopathic physicians.~~

References:

1. **AMERICAN MEDICAL ASSOCIATION (AMA) ISSUE BRIEF, SUMMARY OF EXISTING STUDIES: SCOPE OF PRACTICE, 2022. (ACCESSED 3-26-2025)** https://www.ama-assn.org/system/files/issue-brief-scope-practice-summary-existing-studies.pdf

2. **BLOOMBERG NEWS, THE MISEDUCATION OF AMERICA'S NURSE PRACTITIONERS, 7-24-2024. (ACCESSED 3-26-2025)** https://www.bloomberg.com/news/features/2024-07-24/is-the-nurse-practitioner-job-boom-putting-us-health-care-at-risk?sref=vAuA9CT5&leadSource=uverify%20wall&embedded-checkout=true

Background Information: Provided by AOA Staff
Current AOA Policy: H648/A2020

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted as Amended_

DATE: _____July 19, 2025__________

SUBJECT: DISSEMINATION OF PUBLICATIONS IN OSTEOPATHIC RESEARCH - SOURCE: H-600/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) will widely disseminate publications,
7 research, and evidence-based medicine regarding Osteopathic Medicine and
8 Osteopathic Manipulative Treatment (OMT) and its anatomical and physiological
9 basis to the greater public via prominent, designated public information sites, social
10 networking, public information releases, websites, **AND IN THE DEVELOPMENT**
11 **OF ARTIFICIAL INTELLEGENCE (AI) AS AN ADDITIONAL OPPORTUNITY TO**
12 **DEMONSTRATE THE BENEFITS OF OSTEOPATHIC MEDICINE**~~and other media~~.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: PROPER BADGE IDENTIFICATION OF EMPLOYEES IN A HOSPITAL SETTING - SOURCE: H-604/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) encourages all healthcare providers
7 and hospital employees to wear hospital-issued identification badges with clear
8 delineation of their **LICENSED DESIGNATION** ~~professional role~~ and ~~that~~ they
9 verbally introduce and identify themselves and their **LICENSED DESIGNATION**
10 ~~role in the patient's treatment process~~, with the overall goal of improving patient
11 safety and patient communication.

Background Information: Provided by AOA Staff
Current AOA Policy: 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ______July 19, 2025___________

SUBJECT: ~~HEALTH PLAN~~ **PAYOR** COVERAGE OF TOBACCO CESSATION TREATMENT - SOURCE: H-608/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) encourages all ~~health plans~~
7 **PAYORS** to follow tobacco cessation recommendations of the Centers for Disease
8 Control and Prevention (CDC) and ~~encourages all health care plans~~ to accept CPT,
9 and ICD-10 codes for tobacco use **DISORDER** as legitimate codes for payment ~~for~~
10 **OF** services provided ~~for~~ **BY** these codes.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: NEWBORN AND INFANT HEARING SCREENS
- SOURCE: H-625/A20

SUBMITTED BY: Bureau of Osteopathic Research and Public Health

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Bureau of Osteopathic Research and Public Health has reviewed
3 the policy, now therefore be it

4 RESOLVED, that the Bureau of Osteopathic Research and Public Health
5 recommends that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) supports adequate funding for
7 universal hearing screening and intervention for newborns and infants.

Background Information: Provided by AOA Staff
Current AOA Policy: 1995; 2000 Revised, 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted________

DATE: _____July 19, 2025__________

SUBJECT: PEDIATRIC PSYCHIATRIC CARE ~~HEALTH RECORDS~~ – SOURCE: H617-A/20

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED

The American Osteopathic Association supports the development of educational programs to assist primary care physicians ~~to identify~~ **IN IDENTIFYING** and ~~initiate~~ **INITIATING** appropriate support ~~of~~ **FOR** pediatric psychiatric care, and **THE AOA** encourages **PAYORS** ~~insurance providers~~ to adequately reimburse counseling, ~~and~~ psychiatric care, **AND MEDICATION** deemed **MEDICALLY INDICATED** ~~necessary~~ by the patient's primary care physician.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above, 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: ATTENTION DEFICIT DISORDER / ATTENTION DEFICIT HYPERACTIVITY DISORDER – SOURCE: H-618-A/20

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that this policy is no longer necessary; and

4 WHEREAS, there have been no questions or concerns regarding coverage of
5 services for ADHD by primary care physicians in recent years as such
6 coverage is now standard; now, therefore be it

7 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
8 the following policy be ~~SUNSET~~**REAFFIRMED AS AMENDED**.

9 The American Osteopathic Association (AOA) urges ~~insurance carriers~~ **PAYORS** to
10 provide coverage for **CARE OF** attention deficit disorder/attention deficit
11 hyperactivity disorder (ADD/ADHD) patients by primary care physicians.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above, 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: PRIOR AUTHORIZATION – SOURCE: H642-A/20

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED

The American Osteopathic Association (AOA) adopts the following policy and principles statement on prior authorization.

Prior authorization requirements have been found to result in care delays that place patients at risk and to increase provider burden. ~~In order to~~ **TO** ensure that prior authorization is implemented in an appropriate manner that minimizes burden and risk, the AOA believes that implementation of ~~PA~~ **PRIOR AUTHORIZATION** by ~~payers~~ **PAYORS** 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~~ **PATIENTS SHOULD BE ALLOWED TO CONTINUE ON** medications already being administered or prescribed when ~~a patient~~ **THEY** change~~s~~ health plans**,** and ~~not allow~~ **PLANS SHOULD BE PROHIBITED FROM MAKING** changes without ~~discussion and~~ approval of the ordering ~~physician~~**PRESCRIBER**.

- 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

- **PLANS SHOULD NOT USE AUGMENTED/ARTIFICIAL INTELLIGENCE (AI) TO AUTOMATICALLY DENY PRIOR AUTHORIZATION REQUESTS, AND ALL DENIALS SHOULD BE REVIEWED BY A LICENSED PHYSICIAN IN A SPECIALTY RELEVANT TO THE SERVICE BEING REQUESTED.**

- 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:

- **ELIMINATE PLAN USE OF LOW-VALUE PRIOR AUTHORIZATION REQUIREMENTS, WHERE PLANS IMPOSE REQUIREMENTS FOR SERVICES ROUTINELY APPROVED OR OF LIMITED VALUE TO IMPROVING CARE.**

- 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~~ **PHYSICIANS** hold harmless clauses that indemnify ~~healthcare providers~~ **PHYSICIANS** 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~~**MAKE A TIMELY DECISION**

- Provide appropriate **AND TIMELY** notice to patients and physicians when **BEFORE** formulary and benefit changes are made, **AND INCLUDE** ~~**PREFERRED**~~ **ALTERNATIVE OPTIONS** ~~**THAT MAY BE INDICATED**~~

66 67 68 69
- 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

70 71 72
- Publish and make available to the public all **MEDICAL ITEMS, SERVICES, AND PRODUCTS WHICH WILL REQUIRE PRIOR AUTHORIZATION,** ~~requirements~~ **AND** for prior authorization and follow those published policies

73 74
- ~~**PUBLISH AND MAKE AVAILABLE TO THE PUBLIC**~~ **THE EVIDENCE AND CLINICAL GUIDELINES UPON WHICH COVERAGE CRITERIA ARE BASED**

75 76 77
- 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

78 79
- Compensate medical practices and healthcare providers for the cost of time spent ~~on inappropriately denied PA~~ **PRIOR AUTHORIZATION** requests

80 81 82 83
- ~~To identify and hold accountable the payor's medical director/claim adjudicator for the results of their decisions~~ **TO HOLD PAYORS ACCOUNTABLE FOR FOLLOWING THEIR PUBLISHED POLICIES AND FOR THE RESULTS OR THOSE DECISIONS.**

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above, 2020; Note previous policy numbers of H343-A/13, H602-A/15; H632-A/17, H635-A/19, H637-A/19, and H640-A/16 have been sunset and policy H642-A/20 is the current policy.

Prior HOD action on similar or same topic:

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: MANAGED CARE PLANS – SERVICE, ACCESS AND COSTS IN – SOURCE: H647-A/20

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED AS AMENDED

6 The American Osteopathic Association (AOA) supports **MANAGED CARE PLANS**
7 **HAVING SUFFICIENT FLEXIBILITY TO MANAGE COSTS AND QUALITY WHILE**
8 **BEING ACCOUNTABLE FOR ENSURING ACCESS TO APPROPRIATE**
9 **PATIENT CARE AND PREVENTING UNDUE BURDEN ON PHYSICIANS. THIS**
10 **INCLUDES THE ABILITY OF PLANS TO** ~~efforts to~~ expand the use of variable co-
11 pays **AND OTHER BENEFIT DESIGNS** that support program costs. The AOA also
12 supports efforts to design benefits that align consumer needs, accountability and
13 individual physician incentives.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above, 1999; 2004 Revised; 2009 Reaffirmed as Amended; 2014 Reaffirmed as Amended; 2020 Reaffirmed.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_______

DATE: ____July 19, 2025__________

SUBJECT: ~~Interoperability of~~ Health Information Technology **AND CLINICAL SOFTWARE: INTEROPERABILITY, SAFETY, AND RELIABILITY** – SOURCE: H605-A/20

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, this policy is to be reviewed for sunset; and

WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the policy; and determined that it remains relevant; now, therefore be it

RESOLVED, that the Council on Economic and Regulatory Affairs recommends that the following policy be REAFFIRMED AS AMENDED

The American Osteopathic Association (AOA) supports **A REGULATORY FRAMEWORK FOR HEALTH INFORMATION TECHNOLOGY AND RELATED CLINICAL SOFTWARE THAT APPROPRIATELY BALANCES PATIENT SAFETY, DATA PRIVACY AND SECURITY, USABILITY, AND INNOVATION. AOA SUPPORTS** a ~~new~~ risk-based oversight framework for clinical software, developed through a multi-stakeholder consensus-based process. The framework should take into account risk relative to intended use, cost/benefit of proposed oversight, and the principle of shared responsibility. **POLICY REGARDING PRODUCT APPROVAL OR CERTIFICATION SHOULD EMPHASIZE PATIENT OUTCOMES AND SAFETY; DELIVERY OF PATIENT-CENTERED, WHOLE-PERSON CARE; AND USABILITY OF PRODUCTS BY PHYSICIANS TO ALLEVIATE BURDENS OF SUCH USE.** ~~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~~ **FEDERAL POLICIES** should promote interoperability, in order for clinical information systems to capture and share quality, outcome, cost, and **INDIVIDUAL** patient ~~healthcare~~ data. ~~To support coordinated health care and data analytics to promote transition to a value-based healthcare system.~~ **INTEROPERABILITY IS ESSENTIAL TO COORDINATED CARE AND IMPROVED OUTCOMES NATIONWIDE.** The AOA ~~supports~~ **WILL CONTINUE TO ADVOCATE FOR** a common data structure that will enable interoperability; ~~setting a clear course of action,~~ federal support for an exchange infrastructure; **A NATIONAL NETWORK FOR REPORTING PATIENT SAFETY EVENTS AND OTHER INFORMATION VITAL TO PUBLIC HEALTH**; and standards which will make it easier to share information so physicians and patients

35 can make informed decisions. **THE AOA OPPOSES VENDORS, PROVIDER**
36 **ENTITIES, AND OTHER HEALTHCARE ORGANIZATIONS BLOCKING**
37 **HEALTHCARE PROFESSIONALS' ABILITY TO ACCESS, VIEW, SHARE, OR**
38 **TRANSFER DATA.**
39
40 The AOA will encourage public and private sector stakeholders to develop ~~clinically~~
41 ~~driven, standardized~~ products that are interoperable by design, do not require costly
42 and time-consuming customization, and for which any upgrades or future needs can
43 be integrated seamlessly without burdensome costs or system modifications. The
44 AOA also supports ~~standardization of prior authorization attachments~~ **A**
45 **STANDARDIZED ELECTRONIC PRIOR AUTHORIZATION PROCESS** to alleviate
46 burden and reduce delays to care.
47
48 ~~The AOA opposes vendors blocking health care professionals' ability to access,~~
49 ~~view, share, or transfer data.~~
50
51 ~~The AOA supports policies and technologies that facilitate person-centered health~~
52 ~~care.~~
53
54 The AOA will remain vigilant about mitigating the level of administrative burden
55 posed by existing and new government policies.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above, 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: _____July 19, 2025___________

SUBJECT: ELECTRONIC HEALTH RECORDS – PHYSICIAN ASSISTANCE PROGRAMS FOR TRANSITION TO – SOURCE: H615-A/20

SUBMITTED BY: Council on Economic and Regulatory Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on Economic and Regulatory Affairs has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Council on Economic and Regulatory Affairs recommends that
5 the following policy be REAFFIRMED AS AMENDED

6 The American Osteopathic Association (AOA) will continue to support solo practice
7 physicians and small-group practices in ~~the~~ **THEIR PURSUIT OF** adoption of health
8 information technology (HIT). **THIS INCLUDES THE ADOPTION OF CRITICAL HIT**
9 **ADD-ON FUNCTIONALITIES, SUCH AS POPULATION MANAGEMENT TOOLS**
10 **OR ELECTRONIC PRIOR AUTHORIZATION FUNCTIONS, THAT ARE**
11 **ESSENTIAL TO SUPPORTING IMPROVED CARE AND ENABLING PRACTICES**
12 **TO REMAIN COMPETITIVE WITH LARGER ENTERPRISES**. The AOA supports
13 incentives or enhanced payments for adoption of innovative ~~hit~~ **HIT** that improves
14 care delivery, coordination, and value.

Background Information: Provided by AOA Staff
Current AOA Policy: As noted above, 2005; 2010 Revised; 2015 Reaffirmed as Amended; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: PROVIDER TAX - SOURCE: H611-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED.

7 The American Osteopathic Association (AOA) opposes any effort by a state or the
8 federal government to impose a provider tax of any type.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: _____July 19, 2025________

SUBJECT: **~~EQUITY IN MEDICARE &~~ MEDICAID PAYMENTS**
- SOURCE: H612-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs determined the subject matter of
4 H612-A/20 and H321-A/22 to be substantially similar; and now therefore be it

5 RESOLVED, adding language from H612-A/20 to H321-A/22 and sunsetting H612/-
6 A/20 would provide a clear and comprehensive stance on the issue,
7 eliminate redundancy, and streamline our policy compendium; now, therefore
8 be it further

9 RESOLVED, that the Council on State Health Affairs recommends that the following
10 policy be REAFFIRMED AS AMENDED**.**

11 **~~EQUITY IN MEDICARE &~~ MEDICAID PAYMENTS**

12 The American Osteopathic Association (AOA) will actively support federal
13 legislation, rules or regulations, to include socioeconomic risk stratification in public
14 reporting and evaluation of physician payment in all Medicare and Medicaid pay for
15 performance value-based purchasing incentives or penalties to account for the
16 challenges serving socioeconomically or medically underserved patient populations
17 to ensure continued timely access to appropriate clinical services.

18 The AOA will support federal and state legislation, rules or regulations to improve
19 Medicare and Medicaid payments to physicians **AND HOSPITALS** working in
20 socioeconomic, or medically underserved areas to ensure an adequate workforce to
21 address the burden of care associated with complex comorbid conditions in these
22 areas.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed as Amended; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: _Adopted as Amended__

DATE: ______July 19, 2025___________

SUBJECT: LAY MIDWIVES - SOURCE: H613-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

7 The American Osteopathic Association (AOA) opposes the licensing of lay
8 midwives **WHO LACK FORMAL TRAINING AND CERTIFICATION** and will
9 continue providing support to affiliate societies in opposing state's efforts to license
10 lay midwives.

Background Information: Provided by AOA Staff
Current AOA Policy: 2010; 2015 Reaffirmed; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025___________

SUBJECT: MANAGED CARE – ALL PRODUCTS CLAUSES
- SOURCE: H631-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED**.**

7 The American Osteopathic Association (AOA) ~~and state osteopathic societies~~
8 oppose**S** the use of “all products/all products developed in the future” clauses in
9 physician managed care contracts; actively opposes the use of any other clauses
10 that may limit the ability of the physician to choose the plans in which **THEY** ~~he or~~
11 ~~she~~ participate~~s~~; and supports both state and federal legislation as well as
12 regulatory agency regulations and rulings to prohibit the use of “all products/all
13 products developed in the future” clauses in physician managed care contracts.

Background Information: Provided by AOA Staff
Current AOA Policy: 2000; 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: Adopted as Amended

DATE: July 19, 2025

SUBJECT: NON-PHYSICIAN CLINICIANS - SOURCE: H640-A/20

SUBMITTED BY: Council on State Health Affairs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Council on State Health Affairs has reviewed the policy; and

3 WHEREAS, the Council on State Health Affairs believes that the policy remains
4 relevant; now, therefore be it

5 RESOLVED, that the Council on State Health Affairs recommends that the following
6 policy be REAFFIRMED.

7
8 The American Osteopathic Association (AOA) has adopted the attached policy
9 paper as its position on non-physician clinicians including appropriate onsite
10 supervision.
11
12 Over the course of the past century, scientific and technological advancements
13 have led to improvements in the treatment of disease and standards of patient care.
14 As a result, the standardized medical education, supervised postgraduate
15 ("residency") training and examination series that physicians in the United States
16 are required to complete in order to obtain an unlimited medical license has
17 increased as well. At the same time, however, some states are creating legislative
18 pathways to independent medical practice for other types of clinicians, despite the
19 absence of nationally standardized education, training and testing pathways for
20 these clinician groups, or evidence regarding patient safety outcomes.
21
22 The current DO/MD medical model, in which medical students and resident
23 physicians are required to demonstrate their ability to safely provide care to patients
24 under the supervision of fully licensed physicians, leading to greater autonomy over
25 time, has proven its ability to provide physicians with the complete knowledge and
26 skill base needed to ensure patient safety and optimize outcomes. in addition, most
27 states impose additional continuing medical education (CME) requirements, and
28 many physicians elect to undergo rigorous certifying board examinations to
29 demonstrate excellence in a particular specialty, which helps to ensure that
30 physicians remain trained to provide the current highest standard of patient care
31 over the course of their careers.
32
33 Thus, it is appropriate that the practice of medicine and the quality of medical care
34 remain the responsibility of physicians, who are the only clinician group properly
35 trained, licensed and regulated according to uniform laws governing medical
36 licensure in the United States. The American Osteopathic Association (AOA) values
37 the unique training and contributions of all members of the patient care team and

38 supports the concept of uniform licensure pathways for all clinician groups, based
39 upon scope of practice. The AOA further supports appropriate physician
40 involvement in patient care provided by non-physician clinicians, and opposes any
41 legislation or regulations which would authorize the independent practice of
42 medicine by an individual who has not completed the state's requirements for
43 physician licensure.
44
45 As non-physician clinicians continue to seek wider roles, public policy dictates that
46 patient safety and proper patient care should be foremost in mind when the issues
47 encompassing expanded practice rights for non-physician clinicians – autonomy,
48 scopes of practice, prescriptive rights, liability and reimbursement, among others –
49 are addressed.
50
51 A. Patient Safety. The AOA supports the "team" approach to medical care, with the
52 physician as the leader of that team. The AOA further supports the position that
53 patients should be made clearly aware at all times whether they are being treated
54 by a non-physician clinician or a physician. The AOA recognizes the growth of non-
55 physician clinicians and supports their rights to practice with appropriate physician
56 involvement within the scope of relevant state statutes.
57
58 B. Independent Practice. It is the AOA's position that roles within the "team"
59 framework must be clearly defined, through established state-level supervisory
60 protocols and signed agreements, so physician involvement in patient care is
61 sought when a patient's case dictates and patients can rest assured that physician
62 involvement in their care will remain the same regardless of practice setting within
63 the state. Further, all non-physician clinicians must refer a patient to a physician
64 when the patient's condition is beyond the non-physician clinician's scope of
65 education, training or expertise.
66
67 C. Liability. The AOA endorses the view that physician liability for non-physician
68 clinician actions should be reflective of the quality and degree of supervision being
69 provided and should not exonerate the non-physician clinician from liability. It is the
70 AOA's position that non-physician clinicians providing care in independent practice
71 states should be regulated and disciplined by the entities responsible for regulating
72 and disciplining physicians (i.e. state medical boards), to ensure that all clinicians
73 who are independently practicing medicine are held to the same standard of care
74 and the equivalent degree of liability. To that end, the AOA also believes that non-
75 physician clinicians should be required to obtain equivalent malpractice insurance to
76 physicians in states that currently require physicians to possess malpractice
77 insurance.

Background Information: Provided by AOA Staff
Current AOA Policy: 2000, 2005 Revised; 2010 Revised; 2015 Reaffirmed; 2018 Revised; 2020 Reaffirmed as Amended

Prior HOD action on similar or same topic: H336-A/20 Use of the Term "Physician" "Doctor" and "Provider"; H327-A/21 Non-Physician Health Care Clinician; H626-A/23 Non-Physician Clinician Medical Liability

FISCAL IMPACT: $0

ACTION TAKEN: _____Adopted_____

DATE: ____July 19, 2025__________

SUBJECT: OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) COVERAGE DETERMINATION GUIDANCE – SOURCE: REFERRED-H633-A/24; SR-H635-A/20

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, H633-A/2024 was referred to the Bureau on Federal Health Programs;
2 and

3 WHEREAS, the Bureau on Federal Health Programs has reviewed and amended
4 the referred policy; and

5 WHEREAS, the Board of Trustees approved the amended referred policy (as
6 currently presented to the 2025 House of Delegates), H633-A/2024 AOA
7 OMT Coverage Determination Guidance, as an adopted policy until it can be
8 ratified by the House of Delegates in 2025; therefore, be it

9 RESOLVED, that the Bureau on Federal Health Programs and the Board of
10 Trustees recommends that the referred policy be REAFFIRMED as
11 AMENDED .

12 The American Osteopathic Association (AOA) supports the ability for physicians to
13 bill for Osteopathic Manipulative Treatment (OMT) when performed as a separately
14 identifiable procedure on the same date as an evaluation and management (E/M)
15 service when the services are medically necessary and are supported with
16 appropriate documentation according to the E/M Documentation Guidelines. The
17 AOA will work with all payers to ensure that policies continue to support
18 appropriate payment for OMT when billed with an E/M service. Additionally, the
19 AOA will engage with private payers to ensure that their coverage policies are
20 consistent with current medical practice, to address inappropriate claims denials,
21 and to address blanket denials for services billed with a modifier 25.
22
23 The AOA approves the position paper below for OMT coverage and encourages all
24 public and private payers to refer to AOA's policy when developing new policy or
25 revising existing guidance for OMT coverage. The position paper is intended for
26 use in educational efforts on proper documentation, billing, and payment for OMT;
27 discusses best practices; and acknowledges that documentation by physicians
28 may vary based on individual needs and circumstances that should not serve as a
29 basis for payment denials when services are medically necessary.
30
31 **American Osteopathic Association (AOA) Position Paper on Osteopathic**
32 **Manipulative Treatment**
33

Osteopathic manipulative treatment (OMT) is an essential treatment tool used by physicians for a broad range of conditions, and particularly for treating somatic dysfunction. OMT should be appropriately paid for when it is medically necessary, and documentation of the service is accurate. This document provides guidance to physicians and payers on the following:

- The physicians qualified to provide OMT;
- When payment for OMT services is appropriate;
- Proper documentation and coding of OMT services, including when the service is billed on the same date as an evaluation and management (E/M) service; and
- Appropriate reporting of E/M services in conjunction with OMT.

Physicians are encouraged to use these guidelines to inform best practices for billing, coding, and documentation. Payers should also consider these guidelines in development of coverage policy and should not inappropriately limit payment for medically necessary OMT services.

Introduction to OMT

OMT is a distinct medical procedure used by physicians (DOs/MDs) to treat somatic dysfunction and other conditions. The American Association of Colleges of Osteopathic Medicine (AACOM) Glossary of Osteopathic Terminology defines OMT as the therapeutic application of manually guided forces by a physician to improve physiologic function and/or support homeostasis that has been altered by somatic dysfunction. The AACOM glossary further elaborates on the definition, stating:

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. The positional and motion aspects of somatic dysfunction are best described using at least one of three parameters: (1) the position of a body part as determined by palpation and referenced to its adjacent defined structure, (2) the directions in which motion is freer, and (3) the directions in which motion is restricted.[1]

Somatic dysfunction in one region may lead to compensatory somatic dysfunction in other regions.

Osteopathic manipulative treatment can also be used to treat the somatic component of visceral disease and any organ system, which has the potential to manifest as changes in the skeletal, arthrodial, and myofascial tissues (e.g. tight right shoulder muscles in a patient with gallbladder disease). Normalizing musculoskeletal activity (relaxing tense muscles, etc.) can normalize outflows through sympathetic or parasympathetic autonomic nervous systems to visceral systems, resulting in more normal visceral and organ system function. Somatic

[1] The American Association of Colleges of Osteopathic Medicine (AACOM) **EDUCATIONAL COUNCIL ON OSTEOPATHIC PRINCIPLES (ECOP) GLOSSARY OF OSTEOPATHIC TERMINOLOGY, 3RD EDITION, 2017**. ~~November 2011.~~

dysfunction is identified on the physical exam by one or more of the following elements: **T**issue texture changes, positional **A**symmetry, **R**ange of motion alterations, or changes in palpatory sensitivity, e.g., **T**enderness (TART).

<u>Provider Types Qualified to Perform OMT</u>

To perform OMT, a qualified Doctor of Osteopathic Medicine must have graduated from an accredited school of osteopathic medicine, or a medical doctor must have **GRADUATED FROM AN ACCREDITED ALLOPATHIC SCHOOL OF MEDICINE AND HAVE** trained in ~~a postgraduate osteopathic training program that encompasses~~ osteopathic principles and practices, including hands-on demonstration and competency testing in OMT.

<u>OMT Payment:</u>

The decision to utilize OMT as part of the overall health care of patients is made on a visit-by-visit basis. As such, it is typical to perform a history and physical examination on initial and subsequent encounters. Based on the history and findings of the physical examination, the physician may decide to use OMT as part of the overall care of the patient.

OMT is a paid service when somatic dysfunction is documented in the history and/or the physical examination. OMT is not paid when somatic dysfunction is absent from the patient’s history or physical examination documentation. The method of OMT employed by the physician is determined by the patient’s condition, age, and the effectiveness of previous methods of treatment. Because OMT is a procedure that is separate from the evaluation and management (E/M) service, both services should be payable when rendered on the same day assuming that somatic dysfunction is identified, documentation is appropriate, and that the E/M service is above and beyond the services covered in the OMT and is documented accordingly. Payers should not deny claims on the sole basis that the E/M service is billed with modifier 25 when a procedure was performed on the same date.

<u>OMT Documentation</u>

The medical record documentation must support the level of E/M service billed and include the somatic dysfunction that the physician observed in the body regions treated with OMT. If an E/M service is being reported on the same day as OMT, the documentation should clearly distinguish the elements that constitute the E/M service and the OMT service. Following current E/M coding guidelines, the level of E/M service selected may be based on the total time spent on the E/M portion of the encounter or medical decision making (MDM). Documentation should be consistent with Current Procedural Terminology (CPT©) guidelines to support level selection. The documentation should clearly identify the body regions affected and treated with OMT to support the procedure code(s) reported.

~~The selection of body region(s) to which OMT is applied should reflect the region(s) of documented somatic dysfunction. There may be instances when multiple regions are treated due to the occurrence of compensatory changes. When this occurs, the documentation should describe the compensatory changes and the rationale for treating these areas, especially if the patient has no complaints related to these areas. Treatment should be directed to the areas of documented somatic dysfunction and should not be aimed at areas unrelated to the diagnosis.~~ **THE BODY REGION(S) TO WHICH OMT IS APPLIED MUST BE REFLECTED WITHIN DOCUMENTATION OF SOMATIC DYSFUNCTION. THERE MAY BE INSTANCES WHEN MULTIPLE REGIONS ARE TREATED WHEN THE PATIENT HAS NO COMPLAINTS RELATED TO THESE AREAS. IF THERE IS AN INTERRELATIONSHIP SUCH AS A DISTANT MECHANICAL INFLUENCE OF THE OCCURRENCE OF COMPENSATORY CHANGES, IT IS BEST TO DESCRIBE THOSE WHEN POSSIBLE. TREATMENT SHOULD GENERALLY NOT BE DIRECTED TO AREAS OF DYSFUNCTION UNRELATED TO THE DIAGNOSIS THAT HAVE NO INFLUENCING NATURE.** The type, frequency, and duration of OMT should be consistent with current standards of medical practice.

Factors that may affect frequency and duration of treatment are severity of illness, duration or chronicity of the patient’s condition, and the presence of co-morbidities. These factors should be reflected in the medical record if they contribute to the physician’s treatment approach.

Overall, the American Osteopathic Association recommends that the E/M and OMT portions of the visit be distinctly documented and detail the regions treated, the techniques utilized~~, and when appropriate, a description of how the patient tolerated the treatment.~~ **A DESCRIPTION OF HOW THE PATIENT TOLERATED THE TREATMENT, AND INCLUDE OTHER DETAILS CONSISTENT WITH TYPICAL PROCEDURE DOCUMENTATION.**

<u>OMT Coding</u>

In April 2010, the American Medical Association (AMA) Relative Value Update Committee (RUC) requested that the AOA survey the existing OMT codes to develop accurate and unbiased information for the relative value of the physician work involved in performing OMT as part of the Centers for Medicaid and Medicare Services (CMS) five-year review of the resource based relative value scale (RBRVS).

The survey process required the creation of vignettes to describe the typical patient for OMT CPT® Codes 98925-98929. Additionally, the description of the preservice, intraservice, and postservice work for OMT was included. As of January 2012, the vignettes for the typical patient and the preservice, intraservice and postservice descriptors are contained within the RUC database.

There are five OMT Service CPT© Codes (98925-98929), each corresponding to the number of body regions treated with OMT. Descriptors for each code are the following:

- 98925 *Osteopathic manipulative treatment (OMT); 1-2 body regions involved*
- 98926 *Osteopathic manipulative treatment (OMT); 3-4 body regions involved*
- 98927 *Osteopathic manipulative treatment (OMT); 5-6 body regions involved*
- 98928 *Osteopathic manipulative treatment (OMT); 7-8 body regions involved*
- 98929 *Osteopathic manipulative treatment (OMT); 9-10 body regions involved*

Vignettes and work descriptors for each OMT code can be found in Appendix C of this document. Note: The OMT service codes do not include any elements of the history, examination, and medical decision making.

Reporting E/M Services:

It is appropriate for an E/M service to be performed on initial visits where OMT may be performed, and on subsequent patient encounters if a new problem occurs or if original symptoms have changed. An appropriate significant, separately identifiable E/M service, documented according to the E/M guidelines, may be provided and reported so long as it is considered medically necessary and goes above and beyond the work associated with the OMT procedure itself. As patients may not present for the explicit purpose of undergoing an OMT procedure, the E/M service helps a physician determine if OMT needs to be provided and, if so, what body region(s) to treat and what technique(s) to employ.

A physician should select the appropriate E/M based on MDM or total time of the E/M portion of the encounter, and they should make sure to document a medically appropriate history and/or examination. According to CPT guidelines, four types of MDM are recognized, which include straightforward, low, moderate, and high. MDM "includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option" and is defined by three key elements:

- Number and complexity of the problem(s) addressed during the encounter;
- The amount and/or complexity of data to be reviewed or analyzed; and
- The risk of complications and/or morbidity or mortality of patient management.

Total time may be used alone to select the appropriate code level for E/M services. Time consists of the cumulative amount of face-to-face and non-face-to-face time **personally** spent by the physician in care of the patient on the date of the encounter. Total time can include the following activities when performed:

- preparing to see the patient (e.g., review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record

219 • independently interpreting results (not separately reported) and communicating
220 results to the patient/ family/caregiver
221 • care coordination (not separately reported)
222
223 Physicians should follow the most recent CPT guidance on E/M services
224 whenever billing these services. Documentation for both the E/M and OMT service
225 must be complete when the services are billed on the same day.[2]
226 If utilizing an electronic health record (EHR), ensure that it is capable of capturing
227 all of the history, physical examination and medical decision making and any other
228 service(s) provided on each patient visit.
229 Per CPT © guidance, Evaluation and Management services may be reported
230 separately using Modifier- 25 if the patient's condition requires a significant,
231 separately identifiable E/M service above and beyond the usual preservice and
232 postservice work associated with the OMT procedure. The E/M service may be
233 caused or prompted by the same symptoms or condition for which the OMT
234 service was provided. As such, different diagnoses are not required for reporting
235 of the OMT and E/M service on the same date. Documentation of any changes to
236 symptoms from original visit are vital to the medical necessity of the E/M service.
237
238 **Documenting the Patient Visit: SOAP Note Example[3]:**
239
240 Below is an example of a patient encounter and a subjective, objective,
241 assessment, and plan (SOAP) note for each to illustrate how to document the
242 patient's visit in the medical record. Other styles and preferences exist for medical
243 record documentation. **Note: The E/M service should be a separately
244 identifiable service above and beyond what is normally included in the
245 osteopathic procedure note. If somatic dysfunction is identified in exam and
246 OMT is recommended documentation should include a procedure note. The
247 procedure note should be a separate note following the SOAP note**.
248
249 **E/M visit level can be determined based on either medical decision making
250 (MDM) or total time.**
251
252 SOAP Note – Patient Example
253 S. A 20-year-old African American male complains of low back pain that began three
254 days ago after he lifted a heavy object. Cannot straighten up when walking, pain
255 with change of position. The patient denies radiation of pain and areas of
256 numbness, the pain stays along the back and waist. He is comfortable when lying
257 down, aspirin helps some, has used heat with some help. Has prior history of back
258 pain as a child. Reviewed records provided. Symptoms resolved after undergoing
259 physical therapy. Denies allergies, surgical history is unremarkable.
260 **O. FLEXION POSTURE WHEN STANDING. INABILITY TO EXTEND LUMBAR
261 SPINE ON ACTIVE AND PASSIVE RANGE OF MOTION. TENDERNESS NOTED**

[2] American Medical Association. CPT Evaluation and Management (E/M) Code and Guideline Changes. Effective January 1, 2023. Available here.
[3] American Osteopathic Association. "Guide to Coding and Documentation: Osteopathic Manipulative Treatment, First Edition." 2017

OVER LUMBAR AND SACRAL REGIONS. MUSCLE SPASMS NOTED OF BILATERAL PARASPINAL MUSCULATURE OF THE LUMBAR SPINE. L2 FRRSR. L/R BACKWARD SACRAL TORSION. NEUROLOGIC EXAM WITHIN NORMAL LIMITS. MUSCULOSKELETAL STRENGTH OF BILATERAL LOWER EXTREMITIES EQUAL AND WITHIN NORMAL LIMITS. ~~Tenderness noted over lumbar and sacral regions. Inability to extend lumbar spine when standing. Flexion posture when standing. Muscle spasms noted in paraspinals of the lumbar region. Decreased range of motion of lumbar spine and sacrum was noted on active and passive motion testing. Neurologic exam normal.~~

A. The patient is diagnosed with lumbosacral sprain/strain, likely due to lifting a heavy object. Patient has moderate pain intensity with associated activity limitations.

Lumbosacral sprain/strain S33.8XXA

Note: Based on feedback from insurers and physicians who have completed appeals processes, the AOA encourages inclusion of a narrative of considerations and judgements synthesizing their clinical findings into a clear understanding of the presenting condition and treatment strategies.

P. 1. OMT recommended for the somatic dysfunction of lumbar and sacral regions as noted
2. Continue aspirin
3. No lifting, bending, or twisting
4. Contact office if symptoms worsen

OMT Procedure Note- Patient Example

Patient decided to proceed with OMT recommended. Verbal consent obtained. Discussed risks, benefits, and potential treatment reaction with patient and patient acknowledged comprehension. Patient put in position and technique used to treat the sacral and lumbar spine regions — hypertonic paraspinal muscles and sacral spine- piriformis muscles S2-S4.

Patient tolerated procedure well. Improved Range of Motion noted along with a decreased severity of pain.

Patient instructed to drink fluids today following procedure. Discouraged bedrest and encouraged movement. Contact office if pain increases.

CODING FOR THIS CASE

Evaluation and Management: new patient/established patient 99203/99213 (with modifier 25) **ATTACHING S33.8XXA**
OMT two body regions: lumbar/sacral 98925 **ATTACHING ICD-10 CODE M99.03 AND M99.04**

Conclusion:

OMT is a procedure that is separate from the evaluation and management service, both services should be payable when rendered on the same day considering that somatic

dysfunction is observed and both services are appropriately documented. Physicians should follow the above guidance to ensure that their documentation is appropriate. However, physicians have varying approaches to documentation, and payment should not be denied as long as the E/M service is a significant, separately identifiable service above and beyond the usual preservice and postservice work associated with the OMT procedure. Payers should also consider the above guidelines in developing coverage policies to ensure they are not inappropriately denying medically necessary services.

Appendices

Appendix A: OMT Coding Information

CPT/HCPCS Codes

98925 Osteopathic Manipulative Treatment (OMT); 1-2 Body Regions Involved
98926 Osteopathic Manipulative Treatment (OMT); 3-4 Body Regions Involved
98927 Osteopathic Manipulative Treatment (OMT); 5-6 Body Regions Involved
98928 Osteopathic Manipulative Treatment (OMT); 7-8 Body Regions Involved
98929 Osteopathic Manipulative Treatment (OMT); 9-10 Body Regions Involved

ICD-10 Diagnosis Codes

ICD-10 Codes:

M99.00 Segmental and somatic dysfunction of head region
M99.01 Segmental and somatic dysfunction of cervical region
M99.02 Segmental and somatic dysfunction of thoracic region
M99.03 Segmental and somatic dysfunction of lumbar region
M99.04 Segmental and somatic dysfunction of sacral region
M99.05 Segmental and somatic dysfunction of pelvic region
M99.06 Segmental and somatic dysfunction of lower extremity
M99.07 Segmental and somatic dysfunction of upper extremity
M99.08 Segmental and somatic dysfunction of rib cage
M99.09 Segmental and somatic dysfunction of abdomen and other regions

347 **Appendix B: OMT Techniques are listed below (~~Please refer to~~ including, but not**
348 **limited to those listed in the AACOM Glossary of OMT Terminology ~~for more~~**
349 **~~information~~)**
350
351 Active method
352 Articulatory method
353 Articulatory treatment
354 Articulatory (ART)
355 Balanced ligamentous tension (BLT)
356 Chapman reflex
357 Combined method
358 Combined treatment
359 Compression of the fourth ventricle (CV-4)
360 Counterstrain (CS)
361 Cranial Treatment (CR)
362 CV-4
363 Dalrymple treatment
364 Direct method
365 Exaggeration method
366 Exaggeration technique
367 Facilitated oscillatory release technique (FOR)
368 Facilitated positional release (FPR)
369 **FASCIAL DISTORTION MODEL (FDM)**
370 Fascial release treatment
371 Fascial unwinding
372 Functional method
373 Galbreath treatment
374 Hepatic pump
375 High velocity/low amplitude technique (HVLA)
376 Hoover technique
377 Indirect method (I/IND)
378 Inhibitory pressure technique
379 Integrated neuromusculoskeletal release
380 Jones technique
381 Ligamentous articular strain technique (LAS)
382 Liver pump
383 Lymphatic pump
384 Mandibular drainage technique
385 Mesenteric release technique
386 Muscle energy (**ME**)
387 Myofascial release (MFR) direct and indirect
388 Myofascial technique
389 Myotension
390 Osteopathic ~~in the Cranial Field (OCF)~~**CRANIAL MANIPULATIVE MEDICINE (OCMM)**
391 Passive method
392 Pedal pump
393 Percussion vibrator technique

Positional technique
Progressive inhibition of neuromuscular structure (PINS)
Range of motion technique
Soft tissue **(ST)** technique
Spencer technique
Splenic pump technique
Spontaneous release by positioning
Springing technique
Still technique
Strain-Counterstrain ® **(S/CS)**
Thoracic pump
Thrust technique (HVLA)
Toggle technique
Traction technique
V-spread
Ventral techniques

Appendix C: OMT Vignettes and Coding for 98925-98929

OMT service code 98925: Osteopathic manipulative treatment (OMT); one to two body regions involved.

Vignette:
A 25-year-old female presents with right lower neck pain of two weeks duration. Somatic dysfunction of cervical and thoracic regions is identified on examination.

Description of Preservice Work:
The physician determines which osteopathic techniques (e.g., HVLA, muscle energy, counterstrain, articulatory, etc.) would be most appropriate for this patient, in what order the affected body regions need to be treated, and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.

Description of Intraservice Work:
The patient is initially in the supine position on the treatment table. Motion restrictions of C6 and C7 are isolated through palpation and treated using muscle energy technique. Dysfunctions of T1 and T2 are treated using passive thrust (HVLA) technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.

441 Description of Postservice Work:
442 Post-care instructions related to the procedure are given, including side effects,
443 treatment reactions, self-care, and follow-up. The procedure is documented in the
444 medical record.
445 **OMT Service code 98926:** Osteopathic manipulative treatment (OMT); 3-4 body
446 regions involved.
447
448 Vignette:
449 A 39-year-old female presents with right lower back pain of two weeks duration
450 after a lifting injury. Somatic dysfunction of lumbar, pelvis, and sacral regions are
451 identified on exam.
452
453 Description of Pre-Service Work:
454 The physician determines which osteopathic techniques (e.g., HVLA, Muscle
455 energy, Counterstrain, articulatory, etc.) would be most appropriate for this patient,
456 in what order the affected body regions need to be treated, and whether those
457 body regions should be treated with specific segmental or general technique
458 approaches. The physician explains the intended procedure to the patient, answers
459 any preliminary questions, and obtains verbal consent for the OMT. The patient is
460 placed in the appropriate position on the treatment table for the initial technique
461 and region(s) to be treated.
462
463 Description of Intra-Service Work:
464 The patient is initially in the prone position on the treatment table. Motion
465 restrictions of sacrum and pelvis are isolated through palpation and treated using
466 muscle energy and articulatory techniques. Dysfunctions of L1 and L5 are treated
467 using passive thrust (HVLA) technique. Patient position is changed as necessary
468 for treatment of the individual somatic dysfunctions. Patient feedback and
469 palpatory changes guide further technique application as appropriate.
470
471 Description of Post-Service Work:
472 Post-care instructions related to the procedure are given, including side effects,
473 treatment reactions, self-care, and follow-up. The procedure is documented in the
474 medical record.
475
476 **OMT service code 98927:** Osteopathic manipulative treatment (OMT); five to six
477 body regions involved.
478
479 Vignette:
480 A 17-year-old male presents with pain in the neck, upper and lower back, right
481 shoulder, and right chest following an injury in a high school football game two
482 days prior. Somatic dysfunctions of the right glenohumeral and acromioclavicular
483 joints, as well as the lower cervical, upper thoracic, right upper costal, and lumbar
484 areas are identified on exam.
485
486
487

<u>Description of Preservice Work:</u>
The physician determines which osteopathic techniques (e.g., HVLA, muscle energy, counterstrain, articulatory, etc.) would be most appropriate for this patient, in what order the affected body regions need to be treated, and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.

<u>Description of Intraservice Work:</u>
The patient is initially in a side-lying position on the treatment table. Motion restrictions of identified joints are isolated through palpation and treated using a variety of techniques as follows: acromioclavicular joint is treated with articulatory technique; glenohumeral and costal dysfunctions are treated with muscle energy technique; cervical spine is treated with counterstrain technique; and thoracic and lumbar dysfunctions are treated with passive thrust (HVLA) technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.

<u>Description of Postservice Work:</u>
Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.

OMT service code 98928: Osteopathic manipulative treatment (OMT); seven to eight body regions involved.

<u>Vignette:</u>
A 64-year-old female, in rehabilitation following a left total knee replacement, presents with swelling in the left lower leg, pain in her low back, hips and pelvis with muscle spasms and numbness and bilateral wrist pain with use of a walker. She has a history of widespread degenerative joint disease with stiffness and pain making it difficult for her to actively participate in her rehabilitation program. Somatic dysfunctions of the lumbar, thoracic, and cervical spine, sacrum, pelvis, right leg, and bilateral wrist joints are identified on exam.

<u>Description of Preservice Work:</u>
The physician determines which osteopathic techniques (e.g., HVLA, muscle energy, counterstrain, articulatory, etc.) would be most appropriate for this patient, in what order the affected body regions need to be treated, and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.

535
536 Description of Intraservice Work:
537 The patient is initially in the supine position on the treatment table. Motion
538 restrictions of identified joints are isolated through palpation and treated using a
539 variety of techniques as follows: radiocarpal joints are treated using articulatory
540 and myofascial release techniques; dysfunctions of L3, L5 and SI joints are treated
541 using balanced ligamentous tension technique; dysfunction of C5 through T3, the
542 pelvis and lower extremity are treated with muscle energy technique. Lower
543 extremity edema is treated with lymphatic drainage techniques. Patient position is
544 changed as necessary for treatment of the individual somatic dysfunctions. Patient
545 feedback and palpatory changes guide further technique application as
546 appropriate.
547
548 Description of Postservice Work:
549 Post-care instructions related to the procedure are given, including side effects,
550 treatment reactions, self-care, and follow-up. The procedure is documented in the
551 medical record.
552
553 **OMT service code 98929:** Osteopathic manipulative treatment (OMT); nine to ten
554 body regions involved.
555
556 Vignette:
557 A 40-year-old male presents with sub-occipital headache, and pain in the neck,
558 upper and lower back, left shoulder and chest, and right ankle. He was involved in
559 a rear-end motor vehicle accident two weeks prior. X-rays in the emergency
560 department (ED) were negative. He has been taking prescribed analgesic and
561 muscle relaxant medications with minimal improvement. On examination, somatic
562 dysfunction is identified at the occipitoatlantal, left glenohumeral and right tibiotalar
563 joints, as well as the cervical, thoracic, costal, lumbar, sacral, and pelvic regions.
564
565 Description of Preservice Work:
566 The physician determines which osteopathic techniques (e.g., HVLA, muscle
567 energy, counterstrain, articulatory, etc.) would be most appropriate for this patient,
568 in what order the affected body regions need to be treated, and whether those
569 body regions should be treated with specific segmental or general technique
570 approaches. The physician explains the intended procedure to the patient, answers
571 any preliminary questions, and obtains verbal consent for the OMT. The patient is
572 placed in the appropriate position on the treatment table for the initial technique
573 and region(s) to be treated.
574
575 Description of Intraservice Work:
576 The patient is initially in the supine position on the treatment table. Motion
577 restrictions of identified joints are isolated through palpation and treated using a
578 variety of techniques as follows: occipitoatlantal joint and sacrum are treated using
579 muscle energy and counterstrain techniques; right glenohumeral joint and pelvis
580 are treated with articulatory technique; lumbar, thoracic, cervical, and right ankle
581 are treated with passive thrust (HVLA) technique; costal dysfunctions are treated

582 using muscle energy technique. Patient position is changed as necessary for
583 treatment of the individual somatic dysfunctions. Patient feedback and palpatory
584 changes guide selection of further technique application as appropriate.
585
586 Description of Postservice Work:
587 Post-care instructions related to the procedure are given, including side effects,
588 treatment reactions, self-care, and follow-up. The procedure is documented in the
589 medical record.
590
591 **Sources of Information**

592 American Osteopathic Association Guide to Coding & Documentation: Osteopathic
593 Manipulation Treatment Second Edition (2024)
594 American Osteopathic Association Guide to Coding & Documentation: Osteopathic
595 Manipulative Treatment 1st Edition (2017)
596 American Osteopathic Association (2014).
597 Position paper on Evaluation and Management services (E/M) with Osteopathic
598 Manipulative Treatment (OMT).
599 American Osteopathic Association (1998). Protocols for Osteopathic Manipulative
600 Treatment (OMT).
601 American Association of Colleges of Osteopathic Medicine Glossary of Osteopathic
602 Glossary of OMT Terminology.
603 American Medical Association (AMA) Current Procedural Terminology (CPT©) 2015
604 Manual
605 American Medical Association (AMA) Relative Value Update Committee (RUC) Database

Source: H635-A/20

This resolution is intended to supersede and replace current policy H635-A/20.

Background Information: Provided by AOA Staff
Current AOA Policy: H635-A/20 American Osteopathic Association (AOA) Osteopathic Manipulative Treatment (OMT) Coverage Determination Guidance

Explanatory Statement:
The following grid are the amendments submitted to the Ad Hoc Committee during the 2024 House of Delegates:

Amendment Offered By:	**Amendment**	**Ad Hoc Decision**
California – OPSC	**Line 73: Update Citation** The American Association of Colleges of Osteopathic Medicine (AACOM) - Educational Council on Osteopathic Principles (ECOP) Glossary of Osteopathic Terminology, 3rd edition, 2017.	**Approved**

California – OPSC	**Lines 298 and 299: Add the following** 298 Somatic dysfunction of lumbar region M99.03 299 Somatic dysfunction of sacral region M99.04	**Approved**
California – OPSC	**Lines 255 -261: Replace current language with:** Flexion posture when standing. Inability to extend lumbar spine on active and passive range of motion. Tenderness noted over lumbar and sacral regions. Muscle spasms noted of bilateral paraspinal musculature of the lumbar spine. L2 FRRSR. L/R backward sacral torsion. Neurologic exam within normal limits. Musculoskeletal strength of bilateral lower extremities equal and within normal limits.	**Approved**
Dr. Zaremski	**Lines 133 – 141: Replace current language with:** The body region(s) to which OMT is applied must be reflected within documentation of somatic dysfunction. There may be instances when multiple regions are treated when the patient has no complaints related to these areas. If there is an interrelationship such as a distant mechanical influence or the occurrence of compensatory changes, it is best to describe those when possible. Treatment should generally NOT be directed to areas of dysfunction unrelated to the diagnosis, that have no influencing nature.	**Approved**
Dr. Zaremski	Line 151: Replace current language with: … a description of how the patient tolerated the treatment, and other details consistent with typical procedure documentation.	**Approved**

New York – NYSOMS	**Lines 90-93: Replace current language with:** To perform OMT, any licensed physician must have graduated from a COCA or LCME school that has trained in osteopathic principles and practices, including hands-on demonstration and competency testing in OMT	**Disapproved - Explanatory Statement:** MDs who obtain AOA OMT designation certification can practice OMT. This language will also exclude osteopathic residents and international graduates from practicing/paid for providing OMT.
Wisconsin - WAOPS	**Lines 91 – 93:** …or a medical doctor who trains in a postgraduate osteopathic training program... OR has completed additional CME...	**Disapproved - Explanatory Statement:** MDs who obtain AOA OMT designation certification can practice OMT. Obtaining CME is not sufficient as being trained to perform OMT.
Wisconsin - WAOPS	**Line 101: Add the following** Because the evaluation and decision to utilize OMT and immediate reassessment of somatic dysfunction and symptoms following treatment is performed in the same visit, any subsequent visit should be considered new.	**Disapproved - Explanatory Statement:** CMS has statements regarding what is considered a new patient visit and what is an established patient visit. AOA guidelines must be consistent with code descriptions and CMS guidelines.
Wisconsin - WAOPS	**Line 120: Add after service – Add example** eg. Acute exacerbation of chronic low back pain due to recent garden work. Somatic dysfunction(s) consistent with presentation. Verbal consent for OMT. Immediate improvement in symptoms. Follow up as needed.	**Disapproved - Explanatory Statement:** This is not the area where examples are presented. And in the examples, we want to be simplistic versus extensive. This example was excluded for readability and to avoid confusion.
Wisconsin - WAOPS	**Lines 129 – 133: Strike and replace with:** When this occurs, the documentation should describe the compensatory changes and the rationale for treating these areas, especially if the patient has no complaints related to these areas. Treatment should be directed to the areas of documented somatic dysfunction and should not be aimed at	**Disapproved - Explanatory Statement:** The Ad Hoc Committee approved/adopted an amendment to this section that is more precise.

	areas unrelated to the diagnosis. Because the compensatory changes are due to and could contribute to the maintenance of the main somatic dysfunction, other body regions may need to be address in the same encounter to achieve satisfactory treatment response.	
Dr. Zaremski	**Lines 141 – 142: Strike the following text:** The type, frequency, and duration of OMT should be consistent with current standards of medical practice. Reason: This is overly vague and does not consider the differences between and even within practice specialties, time availability and level of knowledge and skill. Therefore, inappropriate judgements of what constitutes the "standard" will likely be applied.	**Disapproved - Explanatory Statement:** This is CMS language.
Wisconsin - WAOPS	**Line 201: Add the following bullet:** The decision to use OMT would be considered in the "low" to "moderate" MDM based on the risks, benefits, alternatives, contraindications, and patient comorbidities for risk assessment.	**Disapproved - Explanatory Statement:** This is not true in all cases, and we do not want to restrict physicians to only getting paid for OMT when billing low-level E/Ms. This proposed amendment may have unintended payment consequences.
Wisconsin - WAOPS	**Line 228: Add example before "as such,":** Eg. Because "neck pain" treated during initial assessment, now presenting at the base of the shoulders during follow up visit, is a new problem based on anatomic location, and anatomy involved.	**Disapproved - Explanatory Statement:** This is not the area where examples are presented. And in the examples, we want to make as simplistic versus extensive.
Wisconsin - WAOPS	**Line 313: Add the following:** UPDATED EXAMPLE: Assessment and Plan: Cervicalgia, left low back pain without sciatic, somatic dysfunction of ***	**Disapproved - Explanatory Statement:** Only 1 example is presented/needed for each new patient visit and established visit. One would

	Acute on chronic exacerbation of pain from recent car trip. Trial of turmeric and magnesium to address chronic nature of pain. Has improved in past with OMT. No red flags on history or examination. Verbal consent for OMT obtained, see procedural note below. Physical Exam: *** Osteopathic Procedure Note: Osteopathic examination: Cervical: C5-C6 NRrSr, hypertonic paraspinal mm and traps bilaterally R>L Thoracic: Hypertonic PSM Ribs: Thoracic Inlet FRrSr Lumbar: Hypertonic PSM, L3-5 NRrsL Sacrum: Left on left Pelvis: Compressed left SI joint Lower Extremity: HT quads and psoas bilaterally. Treatment modalities include ST, ME, MFR. Patient tolerated procedure well without immediate complication. Reassessment demonstrated improved somatic dysfunction and symptoms. Follow Up: PRN	need to be removed and replaced. So S.O.A.P. needs to be spread out and coding added. And then a separate OMT note.
California – OPSC	**Line 423: Add the following:** Somatic dysfunction of cervical and thoracic regions is identified on examination and management (E/M).	**Disapproved - Explanatory Statement:** This is AMA language from CPT code descriptors, vignettes, and guidelines. It cannot be modified. Background: RUC requested that the AOA review existing OMT codes to develop accurate and unbiased information for the relative

		value of the physician work involved in performing OMT. The survey process resulted in the creation of procedure vignettes for typical patient encounters that include descriptions of the procedure's preservice, intraservice, and post service work for each OMT CPT Code.
California – OPSC	**Lines 560: Add the following** as part of the examination and management (E/M) somatic dysfunction is identified at the occipitoatlantal, left glenohumeral and right tibiotalar joints, as well as the…	**Disapproved - Explanatory Statement:** This is AMA language from CPT code descriptors, vignettes, and guidelines. It cannot be modified.

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended_

DATE: _____July 19, 2025________

SUBJECT: GIFTS TO PHYSICIANS FROM INDUSTRY
- SOURCE: H606-A/20

SUBMITTED BY: Ethics Review and Board Appeals Committee

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Ethics Review and Board Appeals Committee has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Ethics Review and Board Appeals Committee recommends
5 that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) has adopted the following “Guide to
7 Section 17 of the AOA Code of Ethics” as follows and will distribute this information
8 to students of osteopathic medicine and osteopathic physicians.
9
10 1. Physicians’ responsibility is to provide appropriate care to patients. This
11 includes determining the best pharmaceuticals to treat their condition. This
12 requires that physicians educate themselves as to the available alternatives
13 and their appropriateness so they can determine the most appropriate
14 treatment for an individual patient. Appropriate sources of information may
15 include journal articles, continuing medical education programs, and
16 interactions with pharmaceutical representatives.
17
18 2. It is ethical, for osteopathic physicians to meet with pharmaceutical
19 companies and their representatives for the purpose of product education, such
20 as, side effects, clinical effectiveness and ongoing pharmaceutical research.
21
22 3. Pharmaceutical companies may offer gifts to physicians from time to time.
23 These gifts should be appropriate to patient care or the practice of medicine.
24 Gifts unrelated to patient care are generally inappropriate. The use of a product
25 or service based solely on the receipt of a gift shall be deemed unethical.
26
27 4. When a physician provides services to a pharmaceutical company, it is
28 appropriate to receive compensation. However, it is important that
29 compensation be in proportion to the services rendered. Compensation should
30 not have the appearance of a relationship to the physician’s use of the
31 company’s products in patient care.

Background Information: Provided by AOA Staff
Current AOA Policy: 1991, 1994 Revised, 1999, 2003; 2008; 2015 Reaffirmed as Amended; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 19, 2025__________

SUBJECT: CONFIDENTIALITY OF PATIENT RECORDS
- SOURCE: H627-A/20

SUBMITTED BY: Ethics Review and Board Appeals Committee

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Ethics Review and Board Appeals Committee has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Ethics Review and Board Appeals Committee recommends
5 that the following policy be REAFFIRMED.

6 The American Osteopathic Association (AOA) opposes invasion of privacy of the
7 patient record by any unauthorized person or agency; and endorses reasonable
8 programs which seek to protect patient/physician relationships and guarantee
9 confidentiality of patient records.

Background Information: Provided by AOA Staff
Current AOA Policy: 1980; 1985 Revised,1990,1995; 2000, 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ___Adopted______

DATE: _____July 19, 2025________

SUBJECT: EXECUTIONS IN CAPITAL CRIMES CRIMINAL CASES
- SOURCE: H630-A/20

SUBMITTED BY: Ethics Review and Board Appeals Committee

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Ethics Review and Board Appeals Committee has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Ethics Review and Board Appeals Committee recommends
5 that the following policy be REAFFIRMED.

6 The American Osteopathic Association deems it an unethical act for any
7 osteopathic physician to deliver or be required to deliver a lethal injection for the
8 purpose of execution in capital crimes.

Background Information: Provided by AOA Staff
Current AOA Policy: 1995; 2000 Revised; 2005 Reaffirmed; 2010; 2015 Referred; 2020 Reaffirmed

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted_____

DATE: ____July 19, 2025__________

SUBJECT: A PROCLAMATION REGARDING THE INACCURATE PORTRAYALS OF U.S. TRAINED DOs IN MEDIA - SOURCE: H651-A/20

SUBMITTED BY: Ethics Review and Board Appeals Committee

REFERRED TO: Ad Hoc Committee

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1 WHEREAS, this policy is to be reviewed for sunset; and

2 WHEREAS, the Ethics Review and Board Appeals Committee has reviewed the
3 policy; and determined that it remains relevant; now, therefore be it

4 RESOLVED, that the Ethics Review and Board Appeals Committee recommends
5 that the following policy be REAFFIRMED.

6 The leadership and members of the American Osteopathic Association (AOA)
7 condemn the poorly researched and patently incorrect statements regarding the
8 scope of practice of U.S. trained DOs made by journalists.

9 The AOA will continue ongoing efforts using social media and other means to
10 educate the public and dispel inaccuracies of U.S. trained DOs. The AOA
11 encourages its members, affiliated organizations, our patients and our allopathic
12 colleagues to use social media and other means to accurately represent the
13 profession of osteopathic medicine to the public.

14 The AOA will continue to provide online resources and support to its members and
15 advocates to develop a grassroots social media campaign to further the
16 understanding of the profession of osteopathic medicine by the public.

17 The AOA on behalf of the osteopathic profession expresses appreciation and
18 gratitude to the journalists, organizations, and other persons that support an
19 accurate portrayal of osteopathic medicine and osteopathic physicians in the media.

Background Information: Provided by AOA Staff
Current AOA Policy: 2020

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: ____Adopted____

DATE: _____July 19, 2025__________

SUBJECT: PREVENTING THE CRIMINAL PROSECUTION OF MEDICAL DECISION MAKING

SUBMITTED BY: Maine Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, it is essential to the role of osteopathic physicians delivering high quality health care to establish standards of practice, review them critically, and determine when they apply and when other action must be taken; and

WHEREAS, in recent years there has been an increase in the pursuit of physicians as criminals for medical decisions made in good faith, resulting in indictment, conviction, and incarceration of physicians, including leaders of medical academies and known experts[1]; and

WHEREAS, elected bodies including state legislatures, the United States congress, and law enforcement agencies within the Department of Justice, have increasingly been ignoring established rulings of licensure boards and intruding on medical issues regarding which they have had little or no formal education or training and thus inadequate understanding; and

WHEREAS, uninformed and/or rigid implementation of clinical practice guidelines incentivizes the abandonment of our nation’s most complicated and vulnerable patients because of fear of physician prosecution; and

WHEREAS, there are long established, proven mechanisms for self-regulation of physicians through state boards of licensure; now, therefore be it

~~RESOLVED, that the American Osteopathic Association (AOA) will create a distinct division within the Bureau, Committee and Council (B/C/C) structure of the AOA dedicated to monitoring the activities of federal and state law enforcement agencies with regard to criminalization of physician medical decision-making, practice activity, and practice patterns and report to the House of Delegates (HOD); and be it further~~

RESOLVED, that the AOA ~~establish formal~~ **PRIORITIZE** mechanisms to interface with law enforcement agencies within the executive branch of government as well as the federal judiciary to ensure issues of medical decision-making are adjudicated by licensure boards and/or other entities with medical expertise; and be it further

RESOLVED, that the AOA will create a public statement in support of the decision-making system already in place including State Licensing Boards and medical certification boards, for the support of the organization of osteopathic physicians.

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https://www.cdc.gov/media/releases/2019/s0424-advises-misapplication-guideline-prescribing-opioids.html#printhttps://www.justice.gov/opa/pr/justice-department-s-criminal-division-creates-new-england-prescription-opioid-strike-force
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https://www.justice.gov/opa/pr/justice-department-s-criminal-division-creates-new-england-prescription-opioid-strike-force
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https://www.reuters.com/legal/doctors-opioid-prescription-conviction-tossed-after-us-supreme-court-ruling-2023-02-03/
https://www.scientificamerican.com/article/doctors-prescribing-opioids-in-good-faith-should-not-be-prosecuted
https://wgme.com/news/local/she-changed-my-life-patients-surprised-after-maine-doctor-arrested-by-drug-strike-force
https://www.wmtw.com/article/harm-reduction-advocates-defend-maine-doctor-facing-opioid-distribution-charges/43128661#
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[1] https://www.kevinmd.com/2023/07/the-persecution-of-pain-management-doctors.html Arnold DR. Countervailing incentives in value-based payment. Healthc (Amst). 2017 Sep;5(3):125-128. doi: 10.1016/j.hjdsi.2016.04.009. Epub 2016 May 17. PMID: 28822499.

Background Information: Provided by AOA Staff
Current AOA Policy:
H325-A/22 Interference Laws

Prior HOD action on similar or same topic:
This is a resubmission of resolution H630-A24 that was referred to Maine Osteopathic Association after the House of Delegates debated the resolution. AOA's policy (H325-A/22 Interference Laws) on non-interference in the patient-physician relationship is extensive and has a strong position on protecting the patient-physician relationship.

AOA has also engaged with various agencies and state legislatures to protect physicians' autonomy in clinical decision-making.

FISCAL IMPACT: $200,000 Annually
The fiscal impact is an estimate of a new full time AOA staff position (salary and benefits only) and also assumes that all meetings and state/federal government engagement are virtual.

Based on the resolves of the resolution, the new full time AOA staff position would be responsible for:

- Monitoring the activities of federal and state law enforcement agencies with regard to criminalization of physician medical decision-making, practice activity, and practice patterns and report to the House of Delegates (HOD).

- Interface with law enforcement agencies within the executive branch of government as well as the federal judiciary to ensure issues of medical decision-making are adjudicated by licensure boards and/or other entities with medical expertise.

ACTION TAKEN: __Adopted as Amended___

DATE: ____July 19, 2025____________

SUBJECT: PROTECTING PATIENT CARE: OPPOSING THE GROWING IMPACT OF PRIVATE EQUITY AND THE CORPORATE PRACTICE OF MEDICINE

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Ad Hoc Committee

WHEREAS, the Corporate Practice of Medicine Doctrine prohibits corporations from practicing medicine or employing physicians, with the aim of ensuring medical decisions are based solely on patient needs free from profit-driven motives; and

WHEREAS, the Corporate Practice of Medicine prohibition serves to protect patients, preserve the physician-patient relationship, and maintain physician autonomy, as supported by existing AOA policy (H358-A/19); and

WHEREAS, existing AOA policies already recognize the harms to patients resulting from market consolidation and mergers by non-physician corporate entities (H338-A/19, H339-A/19, H617-A/21), without specifically addressing the role of private equity firms; and

WHEREAS, the consolidation of medical practices by private equity firms and other corporate interests has resulted in a majority of physicians being employees with no ownership in their practice (77.6% as of April 2024, up from 40% in 2016)[1,2]; and

WHEREAS, the private equity acquisition of medical practices in rural areas often leads to the consolidation of and subsequent closure of medical practices and rural hospitals - further worsening healthcare access in rural communities; and

WHEREAS, private equity ownership of medical practices creates financial conflicts of interest, which have been shown to degrade quality of healthcare[3,4,5], increase costs[4,6], and undermine physician autonomy and the physician-patient relationship[6]; now, therefore be it

RESOLVED, t~~hat the American Osteopathic Association (AOA) support legislative efforts to protect patient care, access, and the physician-patient relationship by limiting and regulating the Corporate Practice of Medicine, and the acquisition of medical practices, hospitals, and other such institutions by private equity firms~~**TO PROTECT PATIENT CARE, ACCESS, AND THE PATIENT PHYSICIAN RELATIONSHIP, THE AOA SUPPORTS LEGISLATIVE EFFORTS THAT LIMIT AND REGULATE THE CORPORATE PRACTICE OF MEDICINE, INCLUDING ACQUISITION OF**

32 **MEDICAL PRACTICES, HOSPITALS, AND OTHER SUCH INSTITUTIONS**
33 **BY PRIVATE EQUITY FIRMS AND PUBLICY TRADED COMPANIES**
34 **ENTERING HEALTHCARE FOR PROFIT**.

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1. Avalere Health. (2024). COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019-2023. https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023

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3. Forman, A. J. (2022). The Importance of Vigorous Antitrust Enforcement in Health Care. https://www.justice.gov/opa/speech/file/1510391/download

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7. Fogel, A. L., Hogan, S., & Dover, J. (2022). Surgical Dermatology and Private Equity: A Review of the Literature and Discussion. Dermatologic Surgery, 48(3), 339–343. https://doi.org/10.1097/DSS.0000000000003363

Background Information: Provided by AOA Staff
Current AOA Policy: H358-A/19-Interference Laws; H338-A/19-Hospital Consoldation-Opposition to; H339-A/19-Pharmacy Benefit Managers-Increased Regulation of; H617-A/21-Health Insurer Consolidation

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN: __Adopted as Amended__

DATE: ___July 19, 2025____________

SUBJECT: ~~FEDERAL~~ LOAN AVAILABILITY FOR OSTEOPATHIC MEDICAL STUDENTS

SUBMITTED BY: New York Osteopathic Medical Society

REFERRED TO: Ad Hoc Committee

WHEREAS, the House Education and Workforce Committee voted to approve its portion of the federal budget reconciliation bill. Without further correction, this legislation eliminates Grad PLUS Loans and caps federal student professional borrowing at ~~$150,000~~ **$200,000**; and

WHEREAS, a 2013 study of medical school debt by race, it was discovered that more than 62% of surveyed medical students anticipated having debt greater than $150,000[i]; and

WHEREAS, the average total cost of medical school tuition and living expenses is $238,420 ranging from $167,476 for in-state, public schools to $275,068 for out-of-state, private school[ii] [iii]; and

WHEREAS, Additional known expenditures for osteopathic medical students includes taking COMLEX licensing examinations for which Level 1 costs $730, Level 2-CE costs $730, and Level 3 costs $910. Taking all three levels of the COMLEX-USA costs a total of $2,370[iv] (These fees do not include additional costs such as travel to testing centers, preparation materials, or rescheduling fees); and

WHEREAS, other variable expenses include room, board and travel expenses, especially when attending off-site clinical rotations; and

WHEREAS, at a time when our nation faces a growing physician shortage, it is critical that the main sources of financial support being significantly reduced or eliminated not impose unnecessary barriers on future physicians[v]; and

WHEREAS, eliminating the PLUS program would make it harder for future doctors to afford medical school and worsen the physician shortage, especially in rural and underserved communities; and

WHEREAS, the proposed budgetary limits could affect significantly more than 60% of students pursuing medicine and other health professions[vi]; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) ~~work with other interested entities to~~ **WILL WORK WITH RELEVANT STAKEHOLDERS TO** advocate for ~~the restoration of~~ appropriate **LOW-COST GOVERNMENT**

31 **AND PRIVATE** loan availability for **OSTEOPATHIC** medical student
32 education.

Background Information: Provided by AOA Staff
Current AOA Policy:
H343-A/21 White Paper – Improving Access to Physician Led Care
H306-A/23 Federal Student Loan Program

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

[i] Dugger RA, El-Sayed AM, Dogra A, Messina C, Bronson R, Galea S. The color of debt: racial disparities in anticipated medical student debt in the United States. PLoS One. 2013 Sep 3;8(9):e74693. doi: 10.1371/journal.pone.0074693. PMID: 24019975; PMCID: PMC3760863. https://pmc.ncbi.nlm.nih.gov/articles/PMC3760863/

[ii] Hanson, Melanie. "Average Cost of Medical School" EducationData.org, November 9, 2024, https://educationdata.org/average-cost-of-medical-school - https://educationdata.org/average-cost-of-medical-school#:~:text=The%20average%20total%20cost%20of,%2Dstate%2C%20private%20school).

[iii] Hanson, Melanie. "Average Medical School Debt" EducationData.org, August 28, 2024, https://educationdata.org/average-medical-school-debt Average Medical School Debt [2024]: Student Loan Statistics

[iv] https://www.nbome.org/frequently-asked-questions/

[v] https://www.theguardian.com/us-news/2025/jun/01/republican-trump-bill-doctor-shortage

[vi] https://www.urban.org/sites/default/files/2024-06/How_Access_to_Federal_Student_Loans_Could_Change_under_the_CCRA.pdf

ACTION TAKEN: __Adopted as Amended__

DATE: __July 19, 2025____________

AMERICAN OSTEOPATHIC ASSOCIATION

700 Series Joint Budget Resolutions

Actions

AMERICAN
OSTEOPATHIC ASSOCIATION

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105th ANNUAL AOA HOUSE OF DELEGATES MEETING
2025 RESOLUTION ROSTER (700 SERIES)
As of 07-19-25

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTION:
Joint Board/House Budget Review Committee (700 series)
This committee reviews the AOA Strategic Plan and Budget.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-700	Approval to Concur with the AOA FY 2026 Expenditures	Finance Committee	Joint Board House Budget Review Committee	Adopted
H-701	Budget Adjustment Parameters	Finance Committee	Joint Board House Budget Review Committee	Adopted

SUBJECT: Approval to Concur with the AOA FY 2026 Annual Budget

SUBMITTED BY: AOA Finance Committee

REFERRED TO: Joint Board/House Budget Review Committee

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1 WHEREAS the AOA Association's Bylaws Article VII section 1 c. includes that the Board
2 of Trustees "have the responsibility of management of the finances of the
3 Association and shall authorize and supervise, the House of Delegates concurring,
4 with the annual budget for the fiscal year"; and
5
6 WHEREAS, the Joint Board/House Budget Review Committee has convened, reviewed,
7 and approved the AOA FY 2026 Operating Budget, the AOA FY 2026 Capital
8 Expenditures Budget and the AOA FY 2026 142 E. Ontario Building Budget reports
9 as submitted; now therefore be it
10
11 RESOLVED, the American Osteopathic Association House of Delegates
12 approves the AOA FY 2026 Annual Budget as provided.

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

Prior HOD action on similar or same topic: None

ACTION TAKEN: __Adopted_____

DATE: ____July 19, 2025_______

SUBJECT: BUDGET ADJUSTMENT PARAMETERS - SOURCE: H701-A/22

SUBMITTED BY: Finance Committee

REFERRED TO: Joint Board/House Budget Review Committee

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1 WHEREAS, this policy is to be reviewed for sunset every three years; and

2 WHEREAS, the Finance Committee has reviewed the Budget Adjustment
3 Parameters Policy to confirm the policy remains relevant and appropriate and
4 has provided input to the Joint Board/House Budget Review Committee; and

5 WHEREAS, the Joint Board/House Budget Review Committee has reviewed the
6 Budget Adjustment Parameters Policy to confirm the policy remains relevant
7 and appropriate; now, therefore be it

8 RESOLVED, that the Budget Adjustment Parameters policy as noted below has
9 been reviewed by the Finance Committee and Joint Board/House Budget
10 Review Committee and is reported to the House of Delegates with the
11 reference committee report in July 2025.

12 Budget Adjustment Parameters Policy

13 Without explicit approval of the Joint Board/House Budget Review
14 Committee the AOA Board of Trustees may take no financial actions
15 between meetings of the AOA House of Delegates which, when taken
16 together, either decrease AOA's cash or increase its long term or recurring
17 short term debt (to include operating leases and other contractual
18 obligations) to an aggregated amount greater than 10% of the AOA's total
19 equity as audited in the prior year; and, that this policy will be reviewed by
20 the Joint Board/House Budget Review Committee every three years.

Background Information: Provided by AOA Staff
The above budget adjustment parameters were initially approved by the Joint Board/House Budget Review Committee in July 1995. These parameters were re-affirmed by the Joint Board/House Budget Review Committee in July 1998, July 2001, July 2004, July 2007, July 2010, July 2013, July 2016, July 2019 and July 2022.

Current AOA Policy: H701-A22 Budget Adjustment Parameters

ACTION TAKEN: ___Adopted_________

DATE: _____July 19, 2025____________

AMERICAN OSTEOPATHIC ASSOCIATION

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