American Osteopathic Association

House of Delegates

Committee on Public Affairs

Pamela Goldman, DO, Chair — July 27, 2019
Jeffrey Postlewaite, DO, Vice chair — A/2019

CONSENT AGENDA – FOR COLLECTIVE ACTION BY THE HOUSE OF DELEGATES

Mr. Speaker, I present the following Consent Agenda, and the Committee recommends that it be APPROVED:

H-400 PATIENT SAFETY AND USE FOR PATIENTS WITH PAIN CONDITIONS (H400-A/14)

H-401 HUMAN TRAFFICKING – AWARENESS AS A GLOBAL HEALTH PROBLEM (H401-A/14)

H-402 SAME-SEX RELATIONSHIPS AND HEALTHY FAMILIES (H403-A/14)

H-404 ALERT NETWORK – SILVER AND GOLD (H405-A/14)

H-405 ALCOHOL ABUSE (H407-A/14)

H-406 DISCRIMINATION IN HEALTHCARE (H408-A/14)

H-407 SUDDEN INFANT DEATH SYNDROME (H409-A/14)

H-412 FLUORIDATION (H414-A/14)

H-413 MATERNAL AND CHILD HEALTHCARE BLOCK GRANTS (H415-A/14)

Editorial: Line 5…~~m~~Maternal and ~~c~~Child ~~h~~Healthcare ~~b~~Block PROGRAM AND the efficient use of ITS

H-414 EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (H416-A/14)

H-417 VACCINES (H419-A/14)

H-418 DOMESTIC AND INTIMATE PARTNER VIOLENCE – DEVELOPMENT OF PROGRAMS TO PREVENT (H424-A/14)

H-419 HEALTH CARE FRAUD (H425-A/14)

H-420 AUTOMATED EXTERNAL DEFIBRILLATOR AVAILABILITY (H426-A/14)

H-422 LEAD EXPOSURE IN CHILDREN – PREVENTION, DETECTION, AND MANAGEMENT (H431-A/14)

Editorial: Line 6… departments to screen children FOR LEAD based upon current recommendations and guidelines established

H-428 REFERRED SUNSET RES. NO. H-421 - A/2018: H427-A/13 PHYSICIAN-PATIENT RELATIONSHIP AS RELATED TO PROPOSED GUN CONTROL LAWS, PROTECTION OF THE

H-435 RECOGNIZING FOOD INSECURITY AS A PUBLIC HEALTH ISSUE

Editorial: Line 4… percent (15 million) of U.S. households experienced food insecurITY~~e~~

Line 6… with children headed by single WOMEN ~~woman~~ (30.3 percent), Black (non-Hispanic) households

And I so move. **APPROVED**

H-403 PUBLIC INFORMATION – CORRECTION OF, ABOUT THE OSTEOPATHIC PROFESSION (H404-A/14)

Mr. Speaker, I present for consideration Resolution No. H-403, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 2…following policy be ~~SUNSET~~ REAFFIRMED AS AMENDED:
Line 5…The American Osteopathic Association (AOA) will work with ~~Wikipedia and other~~ online
Line 6…public information sites to ~~develop~~ ENSURE THAT content ~~that~~ is accurate and unbiased
Line 8… misinformation ~~on internet encyclopedias, websites, and databases~~ regarding osteopathic

~~Explanatory Statement:~~
~~The Wikipedia rules specifically prohibit employees of an organization from creating content about the organization's focus. The AOA is only permitted to update numbers (per the OMP report) and is not allowed to edit pages or suggest edits.~~

And I so move. **APPROVED**

H-408 PHARMACEUTICALS – SUPPORT EFFORTS TO ENCOURAGE THE PROPER DISPOSAL OF UNUSED AND EXPIRED (H410-A/14)

Mr. Speaker, I present for consideration Resolution No. H-408, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 9… pharmaceuticals in their possession; and ~~will~~ ~~insure~~ENSURE~~S~~ SUPPORTS that such

And I so move. **APPROVED**

Pamela Goldman, DO, Chair GD/ST/TT
Jeffrey Postlewaite, DO, Vice chair

H-410 COMPARATIVE EFFECTIVENESS RESEARCH (H412-A/14)

Mr. Speaker, I present for consideration Resolution No. H-410, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 15… authority**,** ~~or~~ professional autonomy~~.~~**,** AND SHOULD NOT BE USED TO DENY COVERAGE OR PAYMENT.
Line 26… effectiveness~~, and should not be used to deny coverage or payment~~.

And I so move. **APPROVED**

H-416 RAW MILK – HEALTH RISKS (H418-A/14)

Mr. Speaker, I present for consideration Resolution No. H-416, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 5-6… should be required to be pasteurized; ~~supports any government efforts to prohibit the sale and advertisement of raw milk to the public~~; and ~~that~~ ENCOURAGES osteopathic physicians

And I so move. **APPROVED**

H-423 HEPATITIS C SCREENING (H432-A/14)

Mr. Speaker, I present for consideration Resolution No. H-423, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 5… boomers (those born 1945~~6~~-1965~~4~~) in addition to testing those at risk for hepatitis C virus
Lines 7-10… members about HCV, testing strategies, and treatment. ~~The AOA will work with Centers for Medicare and Medicaid Services to remove the restrictive language that only primary care providers can order, and be reimbursed for one-time HCV Screenings for baby boomers (1945~~6~~-1965~~4~~).~~ The AOA will work with public health entities to educate the public about the

And I so move. **APPROVED**

H-425 FIREARM SAFETY (H406-A/14)

Mr. Speaker, I present for consideration Resolution No. H-425, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 5… ~~DURING ROUTINE PATIENT CARE,~~ **WHEN APPROPRIATE,** PHYSICIANS ASK PATIENTS AND/ OR

Lines 8-9… INHERENT IN GUN OWNERSHIP, ESPECIALLY IF **VULNERABLE INDIVIDUALS** ~~CHILDREN AND ADOLESCENTS~~ ARE PRESENT. The AOA RECOMMENDS supports and encourages

Lines 11-13… the inappropriate access to firearms by **VULNERABLE INDIVIDUALS** ~~children and adolescents. and RECOMMENDS supports and encourages all physicians to educate families in the safe use and storage of firearms~~. 1994; revised 1999, 2004; reaffirmed 2009; 2014

And I so move. **APPROVED**

H-426 PROTECTING PATIENTS WITH PRIVATE INSURANCE FROM BALANCE BILLING

Mr. Speaker, I present for consideration Resolution No. H-426, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

SUBJECT: PROTECTING PATIENTS WITH PRIVATE INSURANCE FROM BALANCE BILLING **FOR EMERGENCY MEDICAL CARE**

Lines 12-17…RESOLVED, that the American Osteopathic Association (AOA) ~~will~~ supportS patients' right to access emergency medical ~~procedures~~ CARE at a REASONABLE cost ~~that is based on competitive private market rates~~; and, be it further

RESOLVED, that the AOA, in ~~an~~ emergency medical ~~procedure~~ CARE, supports a system in which patients are removed from the process of resolving outstanding medical expenses that is beyond their cost sharing responsibilities FOR IN-NETWORK CARE; AND, BE IT FURTHER

RESOLVED, THAT DISPUTES OVER THE REASONABLE COST FOR OUT OF NETWORK EMERGENCY CARE BE DETERMINED BY AN INDEPENDENT, THIRD PARTY OR ARBITRATION.

Explanatory Statement: "Surprise billing" results from insurance companies passing out-of-network payment responsibilities to patients. The best practice for resolving payment disputes between insurance companies and care providers is the use of independent third party databases or an Independent Dispute Resolution process using a third party arbiter. This resolution advocates for the inclusion of these best practices in any legislation.

And I so move. **APPROVED**

H-427 REFERRED SUNSET RES. NO. H-403 - A/2018: H403-A/13 AIRBAGS IN AUTOMOBILES

Mr. Speaker, I present for consideration Resolution No. H-427, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

SUBJECT: REFERRED SUNSET RES. NO. H-403 - A/2018: H403-A/13 ~~AIRBAGS IN AUTOMOBILES~~ OCCUPANT PROTECTION IN PASSENGER VEHICLES

Page 7, Line 12… Although some crashes are unavoidable, the probability that passenger vehicle crashes, INJURIES, AND DEATH will continue to decrease

And I so move. **APPROVED**

H-436 COMMUNITY PHARMACIES; REQUIRED NOTIFICATION OF PRIMARY CARE PROVIDERS REGARDING VACCINATION ADMINISTRATION

Mr. Speaker, I present for consideration Resolution No. H-436, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 10…WHEREAS, IN SOME STATES vaccinations can be administered by pharmacists educated in the practice of

Line 16…community-based pharmacy setting, to the patient's primary care physician IN APPROPRIATE REGISTRIES.

And I so move. **APPROVED**

H-437 FIREARM VIOLENCE

Mr. Speaker, I present for consideration Resolution No. H-437, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Lines 1-6…~~WHEREAS, nearly two-thirds of deaths by firearm are related to suicide; and~~
~~WHEREAS, of the remaining one-third of firearm deaths 83% are related to gangs or the drug trade; and~~
~~WHEREAS, the right to keep and bear arms is a constitutionally protected right; and~~
~~WHEREAS, legally owned firearms are used for self-defense 2.4 million times per year, much more than they are used for suicide or to commit crimes; and~~

Line 8…represented by ~~9 separate~~ **MULTIPLE** policies, several of which are due for sunset review in 2020;

Lines 12-14…~~that addresses the core causes of violence and the criminality associated, as well as the mental health issues associated with suicide while upholding the civil rights of law abiding citizens;~~ and, be it further

And I so move. **APPROVED**

H-411 EPIDEMIC TERRORIST ATTACK VICTIMS, GOVERNMENT RESPONSIBILITY OF HEALTH CARE (H413-A/14)

Mr. Speaker, I present for consideration Resolution No. H-411, and the Committee recommends that it be REFERRED to the Bureau of Federal Health Programs (BFHP) for review and comment.

Explanatory Statement: The Committee requires clarity on who should be included, who will benefit, definition of terrorist act, and if this is a national or international policy.

And I so move. **APPROVED** *(for referral to Bureau of Federal Health Programs)*

H-415 BREASTFEEDING WHILE ON METHADONE MAINTENANCE (H417-A/14)

Mr. Speaker, I present for consideration Resolution No. H-415, and the Committee recommends that it be REFERRED to the Bureau of Scientific Affairs and Public Health (BSAPH) for review and comment.

Explanatory Statement: The Committee is requesting an evaluation of breastfeeding and other forms of medical assisted treatments (MAT) for opioid addiction, not limited to methadone.

And I so move. **APPROVED** *(for referral to Bureau of Scientific Affairs and Public Health)*

H-421 MINORITIES, UNDERREPRESENTED – INCREASING NUMBERS OF APPLICANTS, GRADUATES AND FACULTY AT COLLEGES OF OSTEOPATHIC MEDICINE (H429-A/14)

Mr. Speaker, I present for consideration Resolution No. H-421, and the Committee recommends that it be REFERRED to the Bureau of Scientific Affairs and Public Health (BSAPH) and the Bureau of Osteopathic Education (BOE) for review and comment.

Explanatory Statement: This resolution is being referred back for an update of the statistics to determine if the deadline of the goals should be extended.

And I so move. **APPROVED** *(for referral to Bureau of Scientific Affairs and Public Health and Bureau of Osteopathic Education)*

H-424 REGULATION OF E-CIGARETTES AND NICOTINE VAPING (H435-A/14)

Mr. Speaker, I present for consideration Resolution No. H-424, and the Committee recommends that it be REFERRED to the Bureau of State Government Affairs for review and comment.

Explanatory Statement: The Committee requests an updated policy paper.

And I so move. **APPROVED** *(for referral to Bureau of State Government Affairs)*

H-429 CMS RULES ON PSYCHOTROPIC MEDICATIONS IN NURSING FACILITIES

Mr. Speaker, I present for consideration Resolution No. H-429, and the Committee recommends that it be REFERRED to the Iowa Osteopathic Medical Association for review and comment.

Explanatory Statement: The Committee requests clarification as to whether both resolved statements refer to hospice patients or the general patient population in nursing facilities. The Committee further requests clarification on the use of the term psychotropic medication in conjunction with the term antipsychotic medication.

REFERRAL disapproved

Page 2, Lines 2-3 antipsychotic and **OTHER** psychotropic medications **FOR ANY NURSING FACILITY PATIENT**

And I so move. **APPROVED as AMENDED**

H-431 RECOGNITION OF HEALTH CARE AS A HUMAN RIGHT

Mr. Speaker, I present for consideration Resolution No H-431 and the Committee recommends that it be REFERRED to the Michigan Osteopathic Association (MOA) for review and comment.

Explanatory Statement: The committee believes that the resolution, as written, lacks clarity and direction.

And I so move. **APPROVED** *(for referral to the Michigan Osteopathic Association)*

Mr. Speaker, I present the following Consent Agenda, and the Committee recommends that it be DISAPPROVED. To begin discussion, I move that it be approved.

H-409 ADVERTISING - INFLAMMATORY AND UNETHICAL BY ATTORNEYS (H411-A/14)

Explanatory Statement: The Committee believes that this resolution is not directly related to healthcare.

H-432 OSTEOPATHIC PHYSICIANS AND THE AVAILABILITY OF NALOXONE

Explanatory Statement: The Committee believes this resolution is covered under H632 A/18.

H-433 PHYSICIAN AWARENESS OF FIREARM SAFETY IN OLDER PERSONS

Explanatory Statement: This subject is addressed in H-425. Additionally, the white paper only addresses individuals with dementia; it does not specifically address older persons.

And I so move. **APPROVED (for disapproval)**

H-430 OPPOSITION TO PATIENT DISCRIMINATION OF OSTEOPATHIC PHYSICIANS BECAUSE OF RACE, COLOR, RELIGION, GENDER, SEXUAL ORIENTATION, GENDER IDENTITY OR NATIONAL ORIGIN

Mr. Speaker, I present the following Consent Agenda, and the Committee recommends that it be DISAPPROVED. To begin discussion, I move that it be approved.

Explanatory Statement: The Committee believes that the content in this resolution violates the Patient's Bill of Rights and state laws that address this issue vary.

Motion from the floor of the House: Refer to Iowa Osteopathic Medical Association

And I so move. **APPROVED** *(for referral to the Iowa Osteopathic Medical Association)*

H-434 OPPOSING ZERO-TOLERANCE IMMIGRATION POLICIES AND THE SEPARATION OF FAMILIES AT THE BORDER

Mr. Speaker, I present the following Consent Agenda, and the Committee recommends that it be DISAPPROVED. To begin discussion, I move that it be approved.

Explanatory Statement: The Committee believes the resolution does not focus actionable healthcare issues.

And I so move. **APPROVED (for disapproval)**

Mr. Speaker, this concludes the Committee's report. I would like to thank the members of the Committee.

Committee Members:

Pamela SN Goldman, DO - **Chair**	Pennsylvania
Jeffrey Postlewaite, DO - **Vice chair**	Michigan
Tony Khan, DO	California
Wessley Square, OMS	SOMA
Michelle Dilks, DO	Tennessee
Nicklaus Hess, DO	Ohio
Matthew Davis, DO	West Virginia
Stephen Kabel, DO	New Jersey
Nate Delisi, DO	New Hampshire
Alesia Wagner, DO	California
Kendi Hensel, DO	AAO
Charles Chase, DO	Florida
Nicole Bixler, DO	ACOFP
Janet Grotticelli, DO	New York
Micheal Geria, DO	ACOOG

STAFF
Gloria Dillard
Stephanie Townsell
Tennille Tenard

SUBJECT: H400-A/14 PATIENT SAFETY AND USE OF OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) FOR PATIENTS WITH PAIN CONDITIONS

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED:

H400-A/14 PATIENT SAFETY AND USE OF OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) FOR PATIENTS WITH PAIN CONDITIONS

The American Osteopathic Association affirms that OMT is a safe intervention and should be considered as first-line treatment for patients with pain associated with Somatic Dysfunction and other appropriate conditions. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H401-A/14 HUMAN TRAFFICKING – AWARENESS AS A GLOBAL HEALTH PROBLEM

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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

H401-A/14 HUMAN TRAFFICKING – AWARENESS AS A GLOBAL HEALTH PROBLEM

The American Osteopathic Association acknowledges human trafficking as a violation of human rights and a global public health problem; encourages osteopathic physicians to be aware of the signs of human trafficking and the resources available to aid them in identifying and addressing the needs of victims of human trafficking, including appropriate medical assessment and reporting to law enforcement. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H403-A/14 SAME-SEX RELATIONSHIPS AND HEALTHY FAMILIES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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

H403-A/14 SAME-SEX RELATIONSHIPS AND HEALTHY FAMILIES

The American Osteopathic Association (AOA) recognizes the need of same-sex households to have the same access to health insurance and health care as opposite-sex households and supports measures to eliminate discrimination against same-sex households in health insurance and health care. The AOA supports children's access to a nurturing home environment, including through adoption or foster parenting without regard to the sexual orientation or the gender identity of the parent(s). The AOA recognizes and promotes healthy families by lessening disparities and increasing access to healthcare for same-sex marriages and civil unions and the children of those families. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H404-A/14 PUBLIC INFORMATION – CORRECTION OF, ABOUT THE OSTEOPATHIC PROFESSION

SUBMITTED BY: Bureau of International Osteopathic Medicine

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of International Osteopathic Medicine recommend that the following policy be **~~SUNSET~~ REAFFIRMED AS AMENDED**:

H404-A/14 PUBLIC INFORMATION – CORRECTION OF, ABOUT THE OSTEOPATHIC PROFESSION

The American Osteopathic Association (AOA) will work with **~~Wikipedia and other~~** online and public information sites to **~~develop~~ ENSURE THAT** content **~~that~~** is accurate and unbiased and encourage osteopathic physicians to notify the AOA Division of Media Relations to address misinformation **~~on internet encyclopedias, websites, and databases~~** regarding osteopathic medicine. 2014

Explanatory Statement:

~~The Wikipedia rules specifically prohibit employees of an organization from creating content about the organization's focus. The AOA is only permitted to update numbers (per the OMP report) and is not allowed to edit pages or suggest edits.~~

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H405-A/14 ALERT NETWORK – SILVER AND GOLD

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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

H405-A/14 ALERT NETWORK – SILVER AND GOLD

The American Osteopathic Association endorses the wide-spread state adoption of emergency response systems for missing mentally impaired adults throughout the United States, via "Silver Alert" and "Gold Alert" networks which are also known as "Endangered Person Advisory Networks." 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H407-A/14 ALCOHOL ABUSE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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

H407-A/14 ALCOHOL ABUSE

The American Osteopathic Association endorses local, state and federal legislation that would control the consumption and purchase of alcohol by individuals under the age of twenty-one; and urges that alcohol abuse prevention and treatment programs be given a high national priority. 1974; reaffirmed 1978; revised 1983, 1988, 1994, 1997, 1999, 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H408-A/14 DISCRIMINATION IN HEALTHCARE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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

H408-A/14 DISCRIMINATION IN HEALTHCARE
The American Osteopathic Association adopts a zero tolerance policy for all forms of patient discrimination; and in concert with other healthcare organizations, and the federal, state and local governments will continue to monitor, correct and prevent any future negative bias towards one or more patient groups. 1999, revised 2004; reaffirmed as amended 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H409-A/14 SUDDEN INFANT DEATH SYNDROME

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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

H409-A/14 SUDDEN INFANT DEATH SYNDROME

The American Osteopathic Association urges: continued research into the causes and prevention of sudden infant death syndrome (SIDS); that information based on current medical literature be made available to the public on the nature of sudden infant death syndrome and proper counseling be available to families who lose infants to this disease; and supports the US DEPARTMENT OF HEALTH AND HUMAN SERVICES AND CENTERS FOR DISEASE CONTROL AND PREVENTION ~~Public Health Service's~~ campaigns by encouraging its members to educate the parents and care-givers of infants on strategies to reduce the risk of SIDS. 1974; reaffirmed 1980, 1985; revised 1990, 1995, 2000; 2004 reaffirmed 2005; 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H410-A/14 PHARMACEUTICALS – SUPPORT EFFORTS TO ENCOURAGE THE PROPER DISPOSAL OF UNUSED AND EXPIRED

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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

H410-A/14 PHARMACEUTICALS – SUPPORT EFFORTS TO ENCOURAGE THE PROPER DISPOSAL OF UNUSED AND EXPIRED

The American Osteopathic Association ~~will work with~~ SUPPORTS ~~the appropriate regulatory / environmental and public health agencies to encourage~~ the development of educational materials for the public BY THE APPROPRIATE REGULATORY/ENVIRONMENTAL AND PUBLIC HEALTH AGENCIES on the dangers of keeping unused and expired pharmaceuticals in their possession; and will ~~insure~~**ENSURE** **SUPPORTS** that such materials also include education on the proper disposal of unused and expired pharmaceuticals. 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H411-A/14 ADVERTISING - INFLAMMATORY AND UNETHICAL BY ATTORNEYS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

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

H411-A/14 ADVERTISING - INFLAMMATORY AND UNETHICAL BY ATTORNEYS

The American Osteopathic Association urges the American Bar Association to encourage its members who advertise to employ high ethical standards in their public advertisements AND AVOID INFLAMMATORY OR UNETHICAL ADVERTISING. THE AOA FURTHER ENCOURAGES PHYSICIANS, AND OTHER MEMBERS OF THE PUBLIC, TO REPORT INCIDENTS OF INAPPROPRIATE ADVERTISEMENTS TO STATE BAR ORGANIZATIONS, ATTORNEY PROFESSIONAL ORGANIZATIONS, THE FEDERAL TRADE COMMISSION AND OTHER ORGANIZATIONS WITH POTENTIAL FOR INVESTIGATION. 1989; revised 1994; reaffirmed 1999; revised 2004; reaffirmed 2009; 2014

Reference Committee Explanatory Statement:
The Committee believes that this resolution is not directly related to healthcare.

ACTION TAKEN **DISAPPROVED** *(will be sunset)*

DATE **July 27, 2019**

SUBJECT: H412-A/14 COMPARATIVE EFFECTIVENESS RESEARCH

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED:

H412-A/14 COMPARATIVE EFFECTIVENESS RESEARCH

The American Osteopathic Association (AOA) will continue to engage the osteopathic medical profession in Comparative Effectiveness Research (CER) projects and studies across private organizations and government agencies. The AOA will continue to disseminate CER findings to the osteopathic medical profession, consumers of medical information, patients, family members, and caregivers. The AOA adopts the following principles regarding comparative effectiveness research (2009; reaffirmed as amended 2014):

Physicians and Patients

- Comparative effectiveness research should enhance the ability of osteopathic physicians (DOs) to provide the highest quality care to patients utilizing the best proven and widely accepted evidence based medical information at the time of treatment.
- Comparative effectiveness research should not be used to control medical decision-making authority**, ~~or~~** professional autonomy**~~.~~ AND SHOULD NOT BE USED TO DENY COVERAGE OR PAYMENT.**
- Comparative effectiveness research should enhance, complement, and promote quality patient care, not impede it.
- Guidelines developed as a result of comparative effectiveness research studies should be advisory and not mandatory.
- Comparative effectiveness research should be viewed as a positive development for patients and physicians and a useful tool in the physician's armamentarium, working in concert with patients.
- Physicians in practice should be included in any discussions and decisions regarding comparative effectiveness research.
- Comparative effectiveness research should focus on clinical effectiveness, not cost effectiveness~~**, and should not be used to deny coverage or payment**~~.
- The physician/patient relationship must be protected and the needs of the patients should be paramount.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H413-A/14 EPIDEMIC TERRORIST ATTACK VICTIMS, GOVERNMENT RESPONSIBILITY OF HEALTH CARE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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

H413-A/14 ~~EPIDEMIC~~ TERRORIST ATTACK VICTIMS, GOVERNMENT RESPONSIBILITY OF HEALTH CARE

The American Osteopathic Association ~~believes that~~ SUPPORTS victims of ~~an epidemic~~ terrorist attackS ~~(e.g., anthrax) are victims of a new age conflict against America and as victims of an attack against America; they should~~ TO be eligible for healthcare to be covered by the United States Government. 2004; reaffirmed as amended 2009; reaffirmed 2014

Reference Committee Explanatory Statement:
The Committee requires clarity on who should be included, who will benefit, definition of terrorist act, and if this is a national or international policy.

ACTION TAKEN **REFERRED** *(to Bureau on Federal Health Programs)*

DATE **July 27, 2019**

SUBJECT: H414-A/14 FLUORIDATION

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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

H414-A/14 FLUORIDATION
The American Osteopathic Association supports the fluoridation of fluoride-deficient public water supply. Reaffirmed 2004; 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H415-A/14 MATERNAL AND CHILD HEALTHCARE BLOCK GRANTS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H415-A/14 MATERNAL AND CHILD HEALTHCARE BLOCK GRANTS
The American Osteopathic Association supports government expenditures for THE TITLE V ~~mM~~aternal and ~~c~~Child ~~h~~Healthcare ~~b~~Block ~~g~~Grant PROGRAM and the efficient use of ITS resources. THE AOA ~~and~~ supports ~~maintaining or increasing~~ ENSURING SUFFICIENT funding FOR THIS PROGRAM~~levels for the maternal and child healthcare block grants~~. 1988; revised 1993, 1998, 2003, 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H416-A/14 EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) OF 1974

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

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

H416-A/14 EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) OF 1974

The American Osteopathic Association supports federal legislation to reform the Employee Retirement Income Security Act (ERISA) of 1974 to ensure the ability of states to guarantee that clinical decisions be made by physicians and that patients have legal remedies in state court. THE AMERICAN OSTEOPATHIC ASSOCIATION ALSO SUPPORTS LEGISLATION THAT EXTENDS THESE PROTECTIONS TO CLINICAL DECISIONS IMPACTING PATIENT ACCESS TO PRESCRIPTION DRUGS. 2004; reaffirmed 2009; 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H417-A/14 BREASTFEEDING WHILE ON METHADONE MAINTENANCE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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

H417-A/14 BREASTFEEDING WHILE ON METHADONE MAINTENANCE
The American Osteopathic Association encourages exclusive breastfeeding by mothers in methadone maintenance who are in stable recovery. 2003; reaffirmed as amended 2009; reaffirmed 2014

Reference Committee Explanatory Statement:
The Committee is requesting an evaluation of breastfeeding and other forms of medical assisted treatments (MAT) for opioid addiction, not limited to methadone.

ACTION TAKEN **REFERRED** *(to AOA Bureau of Scientific Affairs and Public Health)*

DATE **July 27, 2019**

SUBJECT: H418-A/14 RAW MILK – HEALTH RISKS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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

H418-A/14 RAW MILK – HEALTH RISKS

The American Osteopathic Association believes that all milk sold for human consumption should be required to be pasteurized; ~~**supports any government efforts to prohibit the sale and advertisement of raw milk to the public**~~; and ~~that~~ ENCOURAGES osteopathic physicians ~~may~~TO educate their patients~~ of both~~ ON the safety concerns and the health risks of consuming raw milk. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H419-A/14 VACCINES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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

H419-A/14 VACCINES
The American Osteopathic Association will continue to promote evidence-based information on vaccination compliance and safety. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H424-A/14 DOMESTIC AND INTIMATE PARTNER VIOLENCE – DEVELOPMENT OF PROGRAMS TO PREVENT

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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

H424-A/14 DOMESTIC AND INTIMATE PARTNER VIOLENCE – DEVELOPMENT OF PROGRAMS TO PREVENT

The American Osteopathic Association will continue to support the efforts of the United States Department of Health and Human Services to develop and foster programs that prevent domestic and intimate partner violence. 1989; revised 1994, 1999; reaffirmed 2004; 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H425-A/14 HEALTH CARE FRAUD

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Public Affairs

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

H425-A/14 HEALTH CARE FRAUD

The American Osteopathic Association urges the Center for Medicare and Medicaid Services (CMS) to: (1) disclose to the public and the medical community the actual amount of "fraud" in dollars, based on the reasonable definition of "fraud" omitting all denied and resubmitted claims and all honest mistakes by physicians and the Medicare carriers; and (2) strongly opposes the use of law enforcement agencies and auditors to enter physicians' offices without prior request, warning or due process under the law for the purpose of confiscating records. 1999; revised 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H426-A/14 AUTOMATED EXTERNAL DEFIBRILLATOR (AED) AVAILABILITY

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

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

H426-A/14 AUTOMATED EXTERNAL DEFIBRILLATOR (AED) AVAILABILITY

The American Osteopathic Association recommends an automated external defibrillator (AED) be placed in as many public places as possible and supports legislation that will limit the liability ~~from placement of~~ FOR INSTALLING an AED for use by the public. 2009; reaffirmed 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

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

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Public Affairs

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

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

The American Osteopathic Association encourages an increase in the total number of URM graduates from colleges of osteopathic medicine by the year 2020 and encourages an increase in the total number of URM faculty by the year 2020. 2014

Reference Committee Explanatory Statement:
This resolution is being referred back for an update of the statistics to determine if the deadline of the goals should be extended.

ACTION TAKEN **REFERRED** *(to AOA Bureau of Scientific Affairs and Public Health and Bureau of Osteopathic Education)*

DATE **July 27, 2019**

SUBJECT: H431-A/14 LEAD EXPOSURE IN CHILDREN – PREVENTION, DETECTION, AND MANAGEMENT

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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

H431-A/14 LEAD EXPOSURE IN CHILDREN – PREVENTION, DETECTION, AND MANAGEMENT

The American Osteopathic Association (AOA) encourageS physicians and public health departments to screen children for lead based upon current recommendations and guidelines established by the US Centers for Disease Control and Prevention'S ~~and the Advisory Committee on~~ Childhood Lead Poisoning Prevention PROGRAM and, encourages the reporting of all children with elevated blood lead levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children and, encourages public health policy initiatives that identify exposure pathways for children and develop effective and innovative strategies to reduce overall childhood lead exposure. 2014

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: H432-A/14 HEPATITIS C SCREENING

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H432-A/14 HEPATITIS C SCREENING

The American Osteopathic Association (AOA) publicly supports universal screening of baby boomers (those born 194**56**-196~~5~~4) in addition to testing those at risk for hepatitis C virus (HCV)**,** and~~, the will AOA support and~~ promote public educational programs that educate their members about HCV, testing strategies, and treatment. ~~**The AOA will work with Centers for Medicare and Medicaid Services to remove the restrictive language that only primary care providers can order, and be reimbursed for one-time HCV Screenings for baby boomers (1945**~~**6**~~**-1965**~~**4).**~~ The AOA will work with public health entities to educate the public about the need for testing and treatment. 2014

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: H435-A/14 REGULATION OF E-CIGARETTES AND NICOTINE VAPING

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

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

H435-A/14 REGULATION OF E-CIGARETTES AND NICOTINE VAPING

The American Osteopathic adopts the following policy ~~and recommendations as provided within the attached white paper.~~ 2014

~~**REGULATION OF E-CIGARETTES AND NICOTINE VAPING**~~

~~**BACKGROUND**~~

~~In response to the negative health effects of tobacco products and cigarettes in particular, a natural market for smoking cessation and reduction products has emerged over the last 30 years. Accordingly, the use of electronic cigarettes (e-cigarettes) has reached a rapidly expanding consumer base. E-cigarettes are often used or promoted to reduce consumption of tobacco products. Alternative tools to reach these goals are switching to low or light cigarettes or using nicotine-infused chewing gum, lozenges, lollipops, dermal patches or hypnosis.~~

~~The e-cigarette name is an umbrella term that includes any battery-powered device that vaporizes liquid nicotine for delivery via inhalation. These devices are most commonly referred to as electronic cigarettes, e-cigarettes, e-cigs, vaping, vape pens, vape pipes, hookah pens, e-hookahs, but could potentially be referred to by other terms.~~

~~Since its 2007 introduction in the United States, the e-cigarette market has grown to include more than 250 brands. Sales are expected to reach $1.7 billion by the end of 2013, according to the Attorneys General Association. Over the next decade, it is possible that sales of e-cigarettes will outstrip conventional cigarettes.~~

~~The attraction to e-cigarettes crosses many segments of the population, appealing to the tobacco cigarette smoker trying to quit and the non-smoker who wants to try nicotine without the harmful additives. Tobacco cigarette smokers can also use e-cigarettes as a source of nicotine in venues where conventional cigarettes are banned, although some states and municipalities have also started to ban e-cigarettes in these spaces.~~

~~Smoking costs the United States an estimated $96 billion annually in direct medical expenses and an additional $97 billion in lost productivity. Overall, e-cigarettes may be less harmful for heavy or moderate smokers because they may reduce exposure to carcinogens and other toxic chemicals that cause serious disease and death. However, the effect of long term consumption of only nicotine is unknown, and e-cigarettes have already been shown to leave behind indoor air pollution that could be both hazardous to users themselves along with second hand users. Additionally, many users of e-cigarettes are using them in a supplemental fashion, while continuing to utilize traditional tobacco cigarettes.~~

~~ANALYSIS~~

~~The Food and Drug Administration (FDA) does not currently regulate e-cigarettes. The Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act), provides the FDA authority to regulate the manufacture, marketing and distribution of tobacco products. However, e-cigarettes are not in the purview of FDA regulation of tobacco products. Unlike tobacco cigarettes, e-cigarettes enjoy the ability to advertise on television and radio. This allows e-cigarette companies to market their product in a more liberal fashion in response to market demands, including the use of celebrity endorsements.~~

~~The Composition of E-Cigarettes~~

~~The e-cigarette is a smokeless, battery-powered device that vaporizes liquid nicotine for delivery via inhalation. The e-cigarette contains nicotine derived from tobacco plant and several secondary chemical ingredients. It is primarily composed of a nicotine cartridge, atomizer, and a battery. The atomizer, which converts the nicotine liquid into a fine mist, consists of a metal wick and heating element. When screwed onto the cartridge, the nicotine liquid from the cartridge comes into contact with the atomizer unit and is carried to the metal coil heating element. A single cartridge can hold the nicotine equivalent of an entire pack of traditional cigarettes.~~

~~While the typical e-cigarette is sold in the shape of a cigarette, many products are sold in the shape of discreet objects such as pipes, pens and lipsticks. Often, they can be legally used where traditional tobacco products are banned.~~

~~Federal Efforts to Regulate~~

~~The FDA can regulate e-cigarettes only if the manufacturers make a therapeutic claim, such as e-cigarettes are to be used as a cessation device. The FDA jurisdictional authority covers various products including food, cosmetics, animal and human drugs, medical devices and radiological products. Currently, e-cigarettes do not fall within the jurisdiction of the FDA.~~

~~The FDA has made efforts to regulate e-cigarettes. When the FDA made a determination that certain e-cigarettes were unapproved drug/device combination products, they seized e-cigarettes being imported by Sottera, Inc., resulting in a lawsuit between the company and the FDA. The court held that the FDA lacked authority under the drug/device provisions to regulate tobacco products customarily marketed without claims of therapeutic effect.~~

~~This ruling offers new challenges to FDA regulation because of the novel method of nicotine delivery, various mechanical and electrical parts, and nearly nonexistent safety data. Consumer use, marketing, promotional claims and technological characteristics of e-cigarettes have also raised decade-old questions of when the FDA can assert authority over products as drugs or medical devices.~~

~~State Efforts to Regulate~~

~~Attorneys General from 40 states have urged the FDA to regulate e-cigarettes. The pressure is mounting because of various reasons. For example, unlike traditional tobacco products, there are no federal age restrictions that would prevent children from obtaining e-cigarettes, nor are there any advertising restrictions.~~

~~Various jurisdictions, both states and municipalities, have enacted laws requiring licenses to sell e-cigarettes and banning sales to minors. A distinctive feature of the TCA is the broad latitude expressly preserved to state and local authority to regulate tobacco products. Thirty-nine states and 3,671 municipalities already have laws in place restricting or prohibiting smoking in public places and workplaces. ; Currently, there are 100 local laws restricting e-cigarette use in 100%~~

~~smoke-free venues. However, there are only 3 state laws restricting e-cigarette use in 100% smoke-free venues and only 9 in other venues.~~

~~New Jersey became the first state to amend its public smoking laws to prohibit the use of e-cigarettes in all enclosed indoor places of public access as well as in working places. ; Minnesota enacted laws regulating the sale of e-cigarettes and impose criminal penalties for the sale of e-cigarettes to minors. New Hampshire also enacted a law that prohibits the sale of e-cigarettes and liquid nicotine to minors and distribution of free samples of such products in a public place. New Hampshire also prohibits the use of such products on the grounds of any public educational facility. Similarly, Utah enacted a regulation controlling the sale, gift and distribution of e-cigarettes by manufacturers, wholesalers, and retailers, and King County, Washington enacted an ordinance that bans the smoking of e-cigarettes in public places. Some state and local restrictions on the use of e-cigarettes are driven largely by the concern that they have similar damaging effects on bystanders as traditional cigarettes.~~

~~Arguments for E-Cigarettes~~

~~Smoking accounts for nearly 5.4 million cancer-related deaths worldwide each year. This includes 443,000 deaths in the United States. Proponents argue that e-cigarettes do not expose the user, or others close by, to harmful levels of cancer-causing agents and other dangerous chemicals normally associated with traditional tobacco products.~~

~~Various physician groups have defended the product, based on their opinion that e-cigarettes deliver nicotine without the tar and myriad of other chemicals found in regular cigarettes. At this point, no one knows whether the e-cigarette alternative to tobacco cigarettes carry any long-term detrimental health effects, however it is known that they contain less carcinogenic elements than traditional tobacco cigarettes. According to the American Lung Association there are approximately 600 ingredients in cigarettes. When burned, they create more than 4,000 chemicals. At least 50 of these chemicals are known to cause cancer, and many are poisonous. While e-cigarettes may have less component chemicals, a study found that the usage of e-cigarettes contributes to indoor air pollution. The results showed that e-cigarettes are not emission free, and that their pollutants could be a danger to both users as well as secondhand smokers.~~

~~The draw of the e-cigarette for smoking cessation is that it delivers nicotine to counter nicotine withdrawal symptoms. E-cigarettes evoke the psychological response to cigarette smoking because of its shape and the familiar behavior aspect of smoking. A 2011 survey of 104 e-cigarette users revealed that 66% started using them with the intention to quit smoking and almost all felt that the e-cigarette had helped them to succeed in quitting smoking. Another survey of 3,037 users of e-cigarettes revealed that 77% of them said that they used them to quit smoking or to avoid relapse. None said they used them to reduce consumption of tobacco with no intent to quit smoking. However, the overall effectiveness of e-cigarettes is still in question. In a randomized study, participants given e-cigarettes, nicotine patches and placebo e-cigarettes that lacked nicotine were able to quit smoking at roughly the same rates, with insufficient statistical power to conclude superiority of nicotine e-cigarettes.~~

~~Consequences of E-Cigarettes~~

~~Charting in unknown territory always poses the risk for consequences. Advocates contend that e-cigarettes are less risky and harness the possibility to reduce smoking or even be a complete smoking cessation. A major concern is that it appeals to youth by being flavorful, trendy and a convenient accessory. The flavorings being used, such as candy and other sweet flavorings are~~

~~particularly appealing to younger populations. For this reason, these flavorings are banned in traditional cigarettes.~~

~~Further, e-cigarette usage among children is increasing. During 2011-2012, the percentage of middle school students who have tried e-cigarettes jumped from 1.4% to 2.7%. Among high school students, the jump was from 4.7% to 10%, and 80.5% of high-school students who use e-cigarettes also smoke conventional cigarettes. These numbers could also be largely underestimating the percentage of children using e-cigarettes, as many call the devices by other names. Manufacturers and sellers of e-cigarettes have begun using other product names such as "hookah pens," "e-hookahs," or "vape pens." Even though these products differ only in name and appearance from e-cigarettes, many school age children that used these devices failed to identify them as such.~~

~~Aside from the carcinogenic and toxic effects of tobacco, smokers become addicted to the nicotine. Nicotine addiction is characterized as a form of drug dependence recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Nicotine addiction is a combination of positive reinforcements, including enhancement of mood and avoidance of withdrawal symptoms. E-cigarette cartridges contain up to 20 times the nicotine of a single cigarette, and the process of "vaping" lacks the normal cues associated with cigarette completion, such as the butt of the cigarette ending a dose.~~

~~Conditioning has a secondary role in nicotine addiction. Smokers associate particular cues with the high of smoking, often causing relapse when those seeking to quit smoking are confronted with those cues. E-cigarettes allow quitting smokers to respond to those cues. This poses a risk of overconsumption. The lack of finality to an e-cigarette is determined only by the battery or nicotine cartridge. Distinguishable from tobacco cigarettes, smokers who have turned to the e-cigarette no longer have the butt of the cigarette as a cue to stop smoking.~~

~~E-cigarettes are manufactured from metal and ion components that introduce concerns about faulty products and malfunctions. In the United States there has been at least 2 reports of e-cigarettes exploding in users' faces and hands causing severe injuries including blown out teeth, extensive burns and tissue damage to lips and tongues, burns to the hands and hearing and vision loss.~~

~~CONCLUSION~~

The AOA supports FDA and state regulation of the ingredients of all electronic cigarette cartridges, requiring ingredient labels and warnings, and eliminating the usage of flavors ~~that are banned in traditional cigarettes~~.

The AOA supports the FDA and state regulation prohibiting sales and advertisements of electronic cigarettes to persons under the age of 18. Advertisements for electronic cigarettes should be subject to the same rules and regulations that are enforced on traditional cigarettes.

The AOA further encourages federal, state and local government action to banning the use of electronic cigarette devices in spaces where traditional cigarettes are currently barred from use.

The AOA promotes tobacco and nicotine cessation treatment, and the usage of any such treatment that has been proven safe and effective by the FDA.

The AOA supports research by the FDA and other organizations into the health and safety impact of e-cigarettes and liquid nicotine.

THE AOA SUPPORTS PHYSICIANS CONSIDERING THE RISKS OF RECOMMENDING E-CIGARETTES TO PATIENTS, AS WELL AS REQUESTING

THAT THEIR PATIENTS SUBMIT VOLUNTARY REPORTS TO THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES SAFETY REPORTING PORTAL (WWW.SAFETYREPORTING.HHS.GOV) IF THEY SUSTAIN ADVERSE REACTIONS TO E-CIGARETTES.

~~The AOA supports physicians considering the risks of recommending e-cigarettes to patients, as well as requesting that their patients submit voluntary reports to the U.S. department of health and human services safety reporting portal (www.safetyreporting.hhs.gov) if they sustain adverse reactions to e-cigarettes.~~

~~References:~~

~~Jordan Paradise, No Sisyphean Task: How the FDA Can Regulate Electronic Cigarettes, 13 Yale J. Health Pol'y L. & Ethics 326, 329 (2013).~~
~~Id. at 330.~~
~~Jordan Paradise at 329.~~
~~Id.~~
~~Dan Radel, Healthy or Harmful? Smoking out the truth about e-cigarettes, *available* at http://special.app.com/article/20131027/NJLIFE04/310270144/Healthy-or-harmful-Smoking-out-the-truth-about-e-cigarettes~~
~~Id.~~
~~Id. at 331.~~
~~CDC, Smoking-attributable mortality, years of potential life lost, and productivity losses – United States, 2000-2004, 57 morbidity & mortality wkly. rep., 1226, 1226-28 (2008).~~
~~Jordan Paradise at 333.~~
~~Schober W, Szendrei K, Matzen W, Osiander-Fuchs H, Heitmann D, Schettgen T, et al, Use of Electronic Cigarettes (E-Cigarettes) Impairs Indoor Air Quality and Increases FeNO Levels of E-Cigarette Consumers, International Journal of Hygiene Environment and Health, December 2013, available at http://www.ncbi.nlm.nih.gov/pubmed/24373737~~
~~Available at http://publichealthlawcenter.org/sites/default/files/resources/tclc-fs-ftc&tobacco-2012.pdf~~
~~15 U.S.C. § 1335.~~
~~Stuart Elliots, E-Cigarette Makers' Ads Echo Tobacco's Heyday, New York Times, August 29, 2013, available at http://www.nytimes.com/2013/08/30/business/media/e-cigarette-makers-ads-echo-tobaccos-heyday.html~~
~~Jordan Paradise at 353.~~
~~Id. at 353.~~
~~Tobacco fact sheet: Electronic Cigarettes (E-Cigarettes), Legacy for Longer Healthier Lives, available at http://www.legacyforhealth.org.~~
~~Jordan Paradise at 354.~~
~~Id.~~
~~Available at http://www.smokingeverywhere.com/cartridge.php.~~
~~Jordan Paradise at 354.~~
~~Sophie Novack, E-Cigarette Ads spark Lawmakers' Concern for Youth, The National Journal (Sept. 29, 2013).~~
~~Food, Drug, and Cosmetic Act (FDCA), Pub. L. No. 75-717, 52 Stat. 1040 (1938).~~
~~Troutman Sanders, Federal, State, and Local Lawmakers Take Aim at E-Cigarettes, available at www.Tobaccoretailer.com~~
~~Sottera, Inc. v. FDA, 627 F.3d 891 (D.C. Cir. 2010).~~

~~Jordan Paradise at 329.~~
~~Id. at 331.~~
~~Dan Radel supra.~~
~~Id., The National Association of Attorneys General letter to the FDA.~~
~~Jordan Paradise at 374.~~
~~21 U.S.C. § 387g(a)(1)(A).~~
~~Jordan Paradise at 373.~~
~~American Nonsmokers' Foundation., U.S. State and Local Laws Regulating Use of Electronic Cigarettes. www.no-smoke.org.~~
~~Id.~~
~~N.J. Stat. Ann. SEC 26:3D-58.~~
~~Troutman Sandra supra.~~
~~Id.~~
~~Id.~~
~~Id.~~
~~Id.~~
~~Jordan Paradise at 335.~~
~~Tobacco free initiative: tobacco facts, WHO available at http://www.www.who.int/tobacco/mpower/tobacco_facts/en/index.html~~
~~CDC, Current Cigarette Smoking Among Adults – United States, 2011, 309 JAMA 539, 539-40 (2013).~~
~~Daniel J. Denoon, E-cigarettes under fire, No-Smoke Electronic Cigarettes draw Criticism from FDA, quoting Craig Youngblood, president of InLife, e-cigarette company available at www.webmd.com/smoking-cessation/features/ecigarettes-under-fire.~~
~~Troutman Sanders supra.~~
~~Dan Radel, supra quoting Robert Lahita, Chair of Medicine at New Beth Israel Medical Center.~~
~~Dan Radel, supra quoting Thomas Kiklas, Co-Founder of The E-Cigarette Association~~
~~Id.~~
~~Id.~~
~~Schober et al, Use of Electronic Cigarettes (E-Cigarettes) Impairs Indoor Air Quality and Increases FeNO Levels of E-Cigarette Consumers, International Journal of Hygiene Environment and Health.~~
~~Michael B. Siegal et. al., Electronic Cigarettes as a Smoking-Cessation Tool: Results from an online Study, 40 Am. J. Preventive Med. 472, 474 (2011).~~
~~Jonathan Foulds et. al., Electronic Cigarettes (E-Cigs): Views of aficionados and Clinical/public health perspectives, 65 Int'l J. Clinical prac. 1037 (2011)~~
~~Id.~~
~~Id.~~
~~Christopher Bullen, Electronic Cigarettes For Smoking Cessation: A Randomised Controlled Trial, The Lancet, November 16, 2013, available at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2961842-5/abstract~~
~~Jordan Paradise at 329.~~
~~Id.~~
~~Bridget M. Kuehn, supra.~~
~~Sophie Novack, E-Cigarette Ads spark Lawmakers' Concern for Youth, The National Journal (Sept. 29, 2013).~~
~~Id.~~

~~Matt Richtel, E-Cigarettes, By Other Names, Lure Young and Worry Experts, New York Times, March 4, 2014, available at http://www.nytimes.com/2014/03/05/business/e-cigarettes-under-aliases-elude-the-authorities.html?nl=todaysheadlines&emc=edit_th_20140305&_r=0~~

~~Id.~~

~~Neal L. Benowitz, Nicotine Addiction, 362 New. Eng. J. Med. 2295 (2010).~~

~~Am. Psychological Ass'n, Disgnostic and Statistical Manual of Mental Disorders: DSM-IV-TR (4th ed. Text rev. 2000).~~

~~Neal L. Benowitz, supra.~~

~~Jordan Paradise at 335.~~

~~Neal L. Benowitz, supra.~~

~~Jordan Paradise at 359.~~

~~Id. at 335.~~

~~Mikaela Conley, Man Suffers Sever Injuries After E-Cigarette Explodes in his Mouth, ABC News (2012), available at http://www.abcnews.go.com; Electronic Cigarette Explodes in Muskogee Woman's Hand, (2012), available at http://www.fox23.com.~~

Explanatory Statement:
The conclusions in the white paper are still relevant, with one additional edit. The analysis in the body of the white paper is outdated and therefore should be deleted.

Reference Committee Explanatory Statement:
The Committee requests an updated policy paper.

ACTION TAKEN **REFERRED** *(to Bureau of State Government Affairs)*

DATE **July 27, 2019**

SUBJECT: H406-A/14 FIREARM SAFETY

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

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

H406-A/14 FIREARM SAFETY

THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) RECOMMENDS THAT ~~**DURING ROUTINE PATIENT CARE,**~~ **WHEN APPROPRIATE,** PHYSICIANS ASK PATIENTS AND/ OR CAREGIVERS ABOUT THE PRESENCE OF FIREARMS IN THE HOME AND COUNSEL PATIENTS WHO OWN FIREARMS ABOUT THE POTENTIAL DANGERS INHERENT IN GUN OWNERSHIP, ESPECIALLY IF **VULNERABLE INDIVIDUALS** CHILDREN AND ADOLESCENTS ARE PRESENT. The AOA RECOMMENDS ~~supports and encourages~~ strategies such as secure storage and the use of safety locks TO ELIMINATE ~~for eliminating~~ the inappropriate access to firearms by **VULNERABLE INDIVIDUALS** children and adolescents and RECOMMENDS ~~supports and encourages~~ all physicians to educate families in the safe use and storage of firearms. 1994; revised 1999, 2004; reaffirmed 2009; 2014

Explanatory Statement:
This policy was amended to strengthen the recommendation that physicians routinely counsel and provide education on safe use and storage for patients who own firearms and have children in the home.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: PROTECTING PATIENTS WITH PRIVATE INSURANCE FROM BALANCE BILLING **FOR EMERGENCY MEDICAL CARE**

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Public Affairs

WHEREAS, varying state laws to address balance billing have garnered the interest of federal law makers to mandate a federal standard to address the practice of balance billing; and

WHEREAS, 14 percent of emergency department visits are likely to include balance billing[1, 2]; and

WHEREAS, 20 percent of patients admitted to the hospital via the emergency department are likely to receive balance billing[1, 2]; and

WHEREAS, we believe that it is important that patients be protected from egregious balance billing practices; and

WHEREAS, we recognize that physicians practice under a variety of compensation arrangements, e.g., independent contractor, salary, hourly compensation, percentage of gross or net billing, or a combination of these; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) ~~will~~ support**S** patients' right to access emergency medical ~~procedures~~ **CARE** at a **REASONALBE** cost ~~that is based on competitive private market rates~~; and, be it further

RESOLVED, that the AOA, in ~~an~~ emergency medical ~~procedure~~ **CARE**, supports a system in which patients are removed from the process of resolving outstanding medical expenses that is beyond their cost sharing responsibilities **FOR IN-NETWORK CARE; AND, BE IT FURTHER**

RESOLVED, THAT DISPUTES OVER THE REASONABLE COST FOR OUT OF NETWORK EMERGENCY CARE BE DETERMINED BY AN INDEPENDENT, THIRD PARTY OR ARBITRATION.

References

1. C. Garmon and B. Chartock, "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills," Health Affairs Web First, published online Dec. 14, 2016.
2. Cooper, Zack, Fiona Scott Morton. 2016. "Out-of-Network Emergency-Physician Bills – An Unwelcome Surprise," N Engl J Med 2016; 375:1915-1918.

Reference Committee Explanatory Statement:
"Surprise billing" results from insurance companies passing out-of-network payment responsibilities to patients. The best practice for resolving payment disputes between insurance companies and care providers is the use of independent third party databases or an Independent Dispute Resolution

process using a third party arbiter. This resolution advocates for the inclusion of these best practices in any legislation.'

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: REFERRED SUNSET RES. NO. H-403 - A/2018: H403-A/13 ~~**AIRBAGS IN AUTOMOBILES**~~ **OCCUPANT PROTECTION IN PASSENGER VEHICLES**

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, sunset resolution H-403 - A/2018 titled "AIRBAGS IN AUTOMOBILES" was referred to the Bureau on Scientific Affairs and Public Health (BSAPH) to develop a white paper on all automotive safety, including airbags; now therefore be it,

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that H-403 - A/2018 be reaffirmed as amended and the following white paper, titled "OCCUPANT PROTECTION IN PASSENGER VEHICLES", be adopted:

Occupant Protection In Passenger Vehicles

INTRODUCTION

Today, almost every vehicle on the road has safety features that help drivers to be safer, either through protecting drivers and passengers involved in a crash or to preventing passenger vehicle crashes. This paper will provide information on all vehicle safety features and whether or not the feature is federally mandated, as well as recommend associated policy for adoption by the AOA.

OCCUPANT PROTECTION IN PASSENGER VEHICLES

Occupant protection includes safety belts, lower anchor and tethers for children (LATCH), airbags, and active head restraints. These features were designed to protect both drivers and passengers.

In 2016, National Highway Traffic Safety Administration (NHTSA) developed a fact sheet with information on passenger vehicle occupant protection, which included the use of restraints and benefits of safety belts, frontal airbags, and child restraints. According to the fact sheet, safety belts saved an estimated 14,668 lives of passenger vehicle occupants 5 years old and older in 2016, frontal air bags saved an estimated 2,756 lives, and car seats saved an estimated 328 lives of children under the age of 5 years.[1] NHTSA estimated that lap/shoulder safety belts, when used, reduce the risk of fatal injury among front-seat passenger vehicle occupants by 45%; moderate to critical injury to front-seat passenger vehicle occupants by 50%; fatal injury in front-seat light truck occupants by 60%, and moderate to critical injury to front-seat light truck occupants by 65%.[1]

Frontal airbags, combined with lap/shoulder bags offer effective safety protection for passenger vehicle occupants. NHTSA estimated that the use of frontal airbags without safety belts reduced the fatality risk by 11%, and when using safety belts, fatality drops further by 14%. In 2016, frontal airbags saved an estimated 2,756 lives. From 1987, when airbags first began to be installed in passenger vehicles, through 2016, 47,648 lives were saved. [1]

NHTSA estimated that car seat use in passenger vehicles reduce the risk of fatal injury by 71 % for infants younger than 1 year of age and 54 % for toddlers age 1 to 4 years. For infants and toddlers, the risk of fatal injury in light trucks is 58 % for infants younger than 1 year, and 59 % for toddlers ages 1 to 4 years. In 2016, car seat restraints saved an estimated 328 lives of children age 4 years and younger (313 associated with the use of car seats and 15 with the use of adult safety belts). NHTSA estimated that an additional 42 lives could have been saved (a total of 370 children age 4 and younger). Since 1975, the lives of 11,274 children 4 years old and younger involved in automobile accidents were saved because of child restraint use. [1]

There is an abundance of technology available to protect occupants of passenger vehicles. Most of the advancements have been in place for many years. As technology progressed, many of the features improved, resulting in more saved lives.

Safety-Belt Features

While the seat belt is the most important piece of automotive safety equipment, enhanced features have helped the seat belt do its job more efficiently.[2]

On March 1, 1967, the first Federal Motor Vehicle Safety Standard (FMVSS) mandate required that all passenger vehicles have safety belts. FMVSSs are United States federal regulations specifying the design, construction, performance, and durability requirements for passenger vehicles safety-related components, systems, and design features. FMVSSs are developed and enforced by the National Highway Traffic Safety Administration (NHTSA), pursuant to the National Traffic and Motor Vehicle Safety Act of 1966.

Safety belts now have belt tensioners; a device designed to pull a seat belt tight in an accident. This feature helps position passengers properly to take full advantage of a deploying airbag. [2]

Force limiters, companions to belt tensioners, reduce the force of the seat belt above a certain threshold and, in conjunction with belt tensioners and airbags, lessen the risk of upper body injuries to front seat passengers. [2]

Other seatbelt enhancements include inflatable seatbelts and adjustable shoulder anchors. Some car models have inflatable safety belts in the rear seat that reduces the force of the seat belt on passengers involved in an accident. Inflatable safety belts help protect the elderly and children who are the primary rear seat occupants. [2]

Safety belts also have adjustable shoulder anchors that help position the belt across the chest instead of the neck, which helps prevent neck injuries. [2]

Latch (Lower Anchors and Tethers for Children)

All passenger vehicles are now required to have the LATCH system. This system not only encourages the use of child safety seats but also integrates lower anchors and top tether attachment points. These anchors and attachment points allow the installation of the car safety seat to be effortless and eliminate the challenges and incompatibilities of installing a car safety seat. However, in some cars and trucks, the LATCH system is challenging to use correctly. [2]

NHTSA developed a traffic fact sheet that contains information on the fatal motor vehicle crashes and facilities, based on the Fatality Analysis Reporting System (FARS). Assuming that all passenger vehicle crashes have the LATCH system, in 2017, there were 23,351 passenger vehicle occupants killed in fatal crashes, 794 (3.3%) were infants (less than 1 year) to age 14. Of the 794 children killed, 244 (31%) were in a child restraint seat, 202 (25%) were in a lap belt only or shoulder, and lap belt and 103 (13%) were unknown. Of the 39,822 passenger vehicle occupants who survived in fatal crashes, 4,700 (11.8%) were infants (less than 1 year) to age 14 and 509 (11%) was unrestrained. Of the 63,373 passenger vehicle occupants involved in fatal crashes, 5,494 (8.7%) were infants (less than 1 year) to age 14, and 776 (15%) was unrestrained.[3]

Airbags

Since 1998, front airbags have been standard on all new cars, and since 1999, airbags have been standard on light trucks. The on-board computer-connected crash sensors detect a frontal collision and trigger the bags. In a few milliseconds, the bag inflates, then immediately deflates. [2]

Airbags have saved thousands of lives, but they also have the potential to cause children or occupants who do not use a seat belt to suffer injury or even death. [2] "From 1987 to 2015, frontal air bags saved 44,869 lives. That is enough people to fill a major league ballpark."[4] In 2016, the estimated number of lives saved by frontal airbags were 2,756. [4]

According to a Special Crash Investigations Report released in January 2009, from 1990 through January 1, 2009, there have been 296 airbag-related fatalities, (191 children, 92 adult drivers, and 13 adult passengers).[5] Also, the Takata airbag defection has caused 16 deaths in the U.S.; and 24 deaths and 300 injuries worldwide.[4]

Adaptive or dual-stage front airbags were introduced in 2003 and became the standard by 2007. Most airbag systems now have sensors that detect weight and the seat position of the driver and front passenger. The airbag

system will deactivate if it senses that the driver is positioned too close to the wheel or the front passenger or child is out of position. This system minimizes injury from an accident. [2]

Side Airbags. Side-impact airbags protect the torso of front seat passengers. (Consumer Reports 2016) Depending on the passenger vehicle model, side airbags are offered as standard or optional equipment on many new passenger vehicles. [4]

Side Curtain Airbags. Side curtain airbags are designed to prevent occupants from hitting their heads and shielding them from flying debris. They remain inflated longer than other airbags to keep people from being ejected during a rollover or a high-speed side crash. [2]

A standard enacted late in 2007 and effective September 1, 2009, NHTSA mandated that all automakers phase in additional side-impact protection as a standard feature for their cars, trucks, and SUVs by 2013.[7]

Active Head Restraints

In a rear crash, active head restraints move up and forward to cradle the head and absorb energy to diminish whiplash injury. [2]

ACCIDENT AVOIDANCE SYSTEMS

The automotive industry is continually developing traffic safety technologies that will help drivers avoid crashes. Some of these technologies have a warning system and rely on the driver to take corrective action, while others are designed to automatically brake or steer, thus taking an active action approach to accident prevention. These features are expected to contribute to an overall improvement in traffic safety.

AAA Foundation for Traffic Safety developed a research brief that presented the probable safety benefits of various advanced driver assistance systems and provided estimates regarding the numbers of crashes, injuries, and deaths that such systems could have potentially helped to prevent based on the characteristics of the crashes that occurred on U.S. roads in 2016.[8]

According to the brief, the Forward Collision Warning (FCW) could theoretically have prevented an estimated 69-81% of all rear-end crashes, 76-81% of angle crashes, and 23-24% of single-vehicle crashes, totaling approximately 2.3 million crashes and 7,166 fatal crashes per year between 2002 and 2006. In 2016, there were an estimated 1,994,000 crashes, 884,000 injuries and 4,738 deaths that could have been prevented or mitigated by the FCW system if it were a standard feature in all vehicles. [8]

The brief estimated that Lane Departure Warning (LDW) and Lane Keeping Assistance (LKA) technology equipped in passenger vehicles could have theoretically addressed 179,000 crashes and 7,529 fatal crashes annually between 2004 and 2008. In 2016, there were an estimated 519,000 crashes, 187,000 injuries, and 4,654 deaths that could have been prevented or mitigated by LDW or LKA systems. [8]

The brief estimated that blind spot warning systems (BSW) could have prevented approximately 24% of all lane-changing crashes between 2004 and 2008. In 2016, there were an estimated 318,000 crashes, 89,000 injuries, and 274 deaths that could have been prevented by the BSW system. [8]

There is also an abundance of advanced driver assistance technology available. This technology is designed to prevent crashes. The features are relatively new; thus, they will have varying levels of NHTSA recognition.

Forward Collision Prevention/Warning (FCW)

Adaptive Headlights. Adaptive headlights are primarily intended to move side-to-side to help illuminate curves and corners. "These headlights use electronic sensors that can detect your steering angle to swivel based on the direction your car is heading."[9]

Bicycle Detection. The bicycle detection feature alerts the driver to a potential collision with a bicyclist ahead. NHTSA has not set any performance specifications for this feature.[10]

Forward-Collision Warning (FCW). Forward-collision warning utilizes cameras, radar or laser to scan for autos ahead and alert the driver that they are moving toward a vehicle in their path excessively quick and an accident is inescapable. Most Forward-Collision warning systems alert the driver with a visual and or audible

signal to a potential accident, allowing time for a reaction. [2]

This system meets NHTSA performance specifications but is an option on many new cars, SUVs, and trucks.[11]

Left Turn Crash Avoidance. Left turn car avoidance feature monitors traffic when the driver turns left at low speeds. The sensor automatically activates warning sounds, dash lights, and brakes when a driver turns left into another car's path. NHTSA has not set any performance specifications for this feature.[12]

Obstacle Detection. Obstacle detection uses sensors mounted on the front and/or rear bumpers to determine the distance between the car and a nearby object. If an object is detected, the sensor automatically slows down the passenger vehicle. NHTSA has not set any performance specifications for this feature.[13]

Pedestrian Detection. This system utilizes the features of the Forward-Collision Warning system and automatically initiates the car's braking system to protect pedestrians from being hit. The car's camera or radar looks for a pedestrian in the path of the vehicle. Some systems will alert the driver with an audible or visual alert, and some systems will automatically initialize the emergency braking system if the collision is deemed high. [2]

NHTSA has not set any performance specifications for this feature but recognized that this is a promising technology. This system is currently an option on many new cars, SUVs, and trucks. [2]

Breaking, Tire Pressure, and Anti-Rollover

Brake Assist. Brake Assist helps detect when a driver is braking to maximum strength. In conjunction with anti-lock brakes, the system allows braking without locking the wheels. Studies have shown that most drivers are not braking as hard as they can, so Brake Assist intervenes to reach the shortest stop distance possible. [2]

Traction Control. Traction control electronically controls the wheels spinning motion during acceleration to obtain the maximum traction. This system is useful in wet, icy, or snowy conditions. [2]

Electronic Stability Control (ESC). Electronic stability control (ESC) is a step beyond traction control. In order to avoid sliding or skidding, this system helps keep the vehicle on its intended path during a turn. ESC uses a series of sensors connected to a computer to detect wheel speed, steering angle, side movement, and yaw (rotation). If the car drifts outside the intended path, the stability control system momentarily brakes one or more wheels and reduces the power of the engine to pull the car back on track depending on the system. [2]

ESC is particularly useful for tall, heavy-duty vehicles such as sports equipment pickups; helping to keep the vehicle from rollover. [2]

The federal government required stability control on all vehicles by the 2012 model. [2]

Anti-Lock Braking System (ABS). Before the invention of the anti-lock braking system (ABS), car wheels easily locked during hard braking which caused the front tires to slide and made steering impossible; which is dangerous on slippery surfaces. ABS prevents this from occurring. ABS uses sensors that are controlled by a computer on each wheel. The system maximizes the breaking action on each wheel to avoid locking the wheel which results in the driver maintaining control of the car to avoid hitting obstacles. [2]

"Over the past 10 years, most car manufacturers have made ABS standard in their vehicles. The federal government required all new cars to have ABS by September 1, 2011."[14]

Automatic Emergency Braking (AEB). AEB adds to the advantages of forward-crash cautioning. AEB will detect a potential crash, and if the response time is moderate, the vehicle will start braking. [2] This system engages Dynamic Brake Support and Crash Imminent Braking technology.

> **Dynamic Brake Support (DBS) and Crash Imminent Braking (CIB).** If the driver does not brake hard enough to evade a crash, the DBS system will automatically supplement the driver's breaking to avoid the collision. If the driver does not take any action to prevent the accident, the CIB system will automatically apply the car's brakes to slow or stop the vehicle. (National Highway Traffic Safety Administration n.d.) This system has been available on some car models since 2006 but is typically an optional feature on many new cars, SUVs, and trucks.[15] NHTSA does recommend the CIB and DBS system if it meets NHTSA's performance specifications.

Temperature Warning. Temperature warning alerts the driver when the outside temperature is detected to be at or below freezing, which can affect road conditions. NHTSA has not set any performance specifications for this feature.[16]

Hill Descent Assist. Hill descent assist works with the passenger vehicle's existing braking systems to block the driver from going past a certain speed while traveling downhill or on treacherous terrain. If the vehicle begins accelerating past a safe downhill speed, this feature further applies the brakes. NHTSA has not set any performance specifications for this feature.[17]

Hill Start Assist. Hill start assist uses sensors in the vehicle to detect when a vehicle is on an incline. For a set time, the system maintains the brake pressure as the driver switches from the brakes to the gas pedal. Once the driver presses the accelerator, it releases the brake. In cars with a manual transmission, the Hill Start Assist also maintains brake pressure until the driver lets up on the clutch. NHTSA has not set any performance specifications for this feature.[18]

Driver State Monitoring

Tire-Pressure Monitor System. Tire pressure monitoring systems (TPMS) warn drivers of under or overinflated tires. The system helps to increase the car's fuel economy and potentially prevent a tire blowout which can be dangerous at high speeds and lead to a car accident. The federal government required all new vehicles to include this system starting in late 2007.[19]

Curve Speed Warning. Curb speed warning uses Global Positioning System (GPS) to alert the driver of upcoming sharp turns. This feature tracks the passenger vehicle speed and location and warns the driver to slow down when approaching curves and exits. NHTSA has not set any performance specifications for this feature.[20]

High-Speed Alert. High-speed Alert uses a built-in speed sensor and GPS to compare a database of known road speed limit against the driver's actual speed and alerts the driver if they are speeding. Some versions may track school and work zones. Future versions may be able to read limits through a camera. NHTSA has not set any performance specifications for this feature.[21]

Adaptive Cruise Control (ACC). ACC utilizes lasers, radar, cameras, or a blend of these to keep a steady distance between the driver and the vehicle ahead. If the traffic slows, some systems automatically stop the car and automatically accelerate to full speed when the traffic returns to normal. The system allows the driver to lose their focus on driving, which is a hazard. [2]

Push Button Start. Push Button Start simplifies turning the passenger vehicle on and off using a key fob unique to the vehicle. NHTSA has not set any performance specifications for this feature.[22]

Drowsiness Alert. Drowsiness alert borrows some of the sensors from lane departure warning systems to track lane markings and the automobile's lane position. Many versions of this feature will track how often the driver departs from the lane over a short period to determine if the driver may be drowsy. This feature may alert the driver using a coffee cup or other symbol on the dash suggesting that the driver take a break and when it will be safe to pull over. NHTSA has not set any performance specifications for this feature.[23]

Automatic High Beams. Automatic high beam lights switch from high to low and back again to improve nighttime visibility and as conditions warrant. [2]

Parking and Backing Assistance

Backup Camera. The backup camera assistance system is activated when the driver of a passenger places the gear in reverse. The monitor is in the center console of the passenger vehicle and displays items behind the car. This system is primarily used as a parking aid or spotting a child or pedestrian concealed in the blind zone. [2]

NHTSA required this life-saving technology on all new vehicles in May 2018. [11]

Back-up Warning. Back-up warning uses sensors mounted to the rear bumper. These sensors detect objects in the path of the vehicle. The system may beep or vibrate if an object is in the way.[24]

At this time, this is not a new car standard. As stated above, NHTSA required this life-saving technology on all new vehicles in May 2018.[15] In the future, manufacturers are expected to pair the back-up warning and the back-

up camera systems in new cars.

Parking Assist System. Parking assist incorporates sensors in the car's front, rear, or both bumpers. The system alerts the driver that light poles, walls, shrubbery, and other obstacles are close when the passenger vehicle is moving at a slow speed (parking speed). [2]

Automatic Parallel Parking. Automatic parallel parking can detect objects in front and back of a car while parking. It provides audible warnings when detecting one or more objects. Advanced sensors read the gaps between vehicles in the area where the driver chooses to park. The feature will not activate if there is insufficient room to parallel park, which helps ensure that the car does not bump into any nearby vehicles. When initiated, this feature takes over some of the vehicle's steering and acceleration functions needed to park.[25]

Rear Cross-Traffic Alert. Rear cross-traffic alerts sense traffic crossing the path of a passenger vehicle as the driver backs out of a parking space or driveway. Some systems automatically brake to prevent an accident. [2]

The Rear cross-traffic alert system is not a standard feature for passenger vehicles, but the federal government does mandate the feature for such vehicles as buses and trucks. However, manufacturers often pair rear cross traffic alert with back-up cameras; so the mandate may increase the popularity of rear cross traffic alert features soon.[26]

Lane and Side Assistance

Lane-Departure Warning (LDW). Lane-departure warning alerts the driver when the car drifts out of its lane without activating the turn signal. The system uses a camera or lasers to monitor lane markers. The system will chime, the dashboard will blink, or the steering wheel or seat will vibrate to warn the driver that they are drifting into another lane.[2] This system meets NHTSA's performance specifications and is an option on many new cars, SUVs, and trucks. [15]

Lane-Keeping Assist (LKA). Lane-keeping assist will generate mild steering to put the driver back in their lane. This system also senses when the driver leaves their lane. [2]

NHTSA has not set performance specifications for this technology, but this technology may be available on new cars, SUVs, and trucks. [15]

Blind-Spot Warning (BSW) or Blind Spot Detection (BSD). BSW utilizes radars or cameras and shines a light or symbol in or adjacent to the outside mirrors to warn the driver that another vehicle is driving in the parallel lane in an area that the drivers outside mirrors cannot detect. This system will sound an audible warning if the driver attempts to change lanes or uses their turn signal to indicate that they plan to change lanes. There are additional advanced systems that can initiate the braking system or the steering system in order to move the vehicle back towards the center of the lane. [2]

NHTSA has not set performance specifications for BSW, but NHTSA recognizes this as a promising technology. On many new cars, SUVs, and trucks, this system is an option and can help avoid a crash.[14]

Side View Camera. Side view cameras improve visibility on the passenger side, and in some cases provide the driver with a circuit view of the surrounding area of the car. The driver can use this feature to protect bumpers, side mirrors, trim, and wheel rims from damage at low speeds. This camera also provides an expanded view of a lane beside the driver when the driver uses their turn signal or when the driver manually activates this feature. This feature is similar to the blind spot monitor.[27]

Communication

911 Notification - Automatic Crash Notification (ACN). ACN is technology designed to notify emergency responders that an accident has occurred and provide the location. This system uses sensors to detect a deployed airbag or detect a dramatic and sudden deceleration. Once this is detected, the system will automatically connect to an operator who will be able to talk with the accident victims.[15]

This system has the potential to reduce death and disability by reducing the time it takes for emergency medical services to reach an accident scene and transport victims to a hospital.[15]

NHTSA has not set performance specifications for this technology. This system is available as an option on

many new cars, SUVs, and trucks.[15]

Telematics. Telematics is the use of cellular, Global Positioning Satellite (GPS), and other technology (e.g., GM OnStar, BMW Assist, Hyundai Bluelink, Kia UVO, Lexus Safety Connect, Mercedes-Benz's mBrace, and Toyota Safety Connect) to gather and transmit data. "This system allows the driver to communicate with a central dispatch center at the touch of a button. This center knows the location of the vehicle and can provide route directions"[28] of emergency aid on request.[2]

CONCLUSION

There are many safety features to prevent automobile accidents and protect drivers. Because some do carry the potential risk of harm, these features continue to evolve. Research is regularly conducted to ensure that passenger vehicles are able to lessen the impact of crashes, reduce injuries and help drivers prevent crashes. However, consumer education is needed on the proper use of existing safety features. NHTSA, for example, not only conducts research and establish standards, but insurance companies and not-for-profit agencies such as AAA Foundation for Traffic Safety conduct research.

Although some crashes are unavoidable, the probability that passenger vehicle crashes**, INJURIES, AND DEATH** will continue to decrease is high because of the ongoing research, available educational opportunities, and existing and future advanced technologies.

After review of the existing literature on automotive safety, including airbags, the American Osteopathic Association (AOA) adopts the following policies: The American Osteopathic Association:

(1) supports the ongoing efforts of the National Safety Council (NSC), the National Highway Traffic and Safety Administration (NHTSA), the National Transportation Safety Board (NTSB) and other responsible safety organizations to educate the public regarding the proper use of all occupant protection devices in passenger vehicles, including safety belts, child safety seats, and airbags;
(2) urges continued corporate development and research into safer airbags and monitoring of adult and child fatalities resulting from airbag deployment; and
(3) encourages the National Safety Council, the National Highway Traffic and Safety Administration, the National Transportation Safety Board, and other responsible safety organizations to educate the public regarding the benefits and potential dangers of all occupant protection equipment and accident avoidance systems.

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ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: REFERRED SUNSET RES. NO. H-421 - A/2018: H427-A/13 PHYSICIAN-PATIENT RELATIONSHIP AS RELATED TO PROPOSED GUN CONTROL LAWS, PROTECTION OF THE

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

WHEREAS, sunset resolution H-421-A/2018 titled "H427-A/13 PHYSICIAN-PATIENT RELATIONSHIP AS RELATED TO PROPOSED GUN CONTROL LAWS, PROTECTION OF THE" was referred to the Bureau on Scientific Affairs and Public Health (BSAPH); now, therefore be it

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

H427-A/13 PHYSICIAN-PATIENT RELATIONSHIP AS RELATED TO PROPOSED GUN CONTROL LAWS, PROTECTION OF THE

While the American Osteopathic Association supports measures that save the community at large from gun violence, the AOA opposes public policy that mandates reporting of information regarding patients and gun ownership or use of guns except in those cases where there is duty to protect, as established by the Tarasoff ruling, for fear of degrading the valuable trust established in the physician-patient relationship. ~~THE AOA RECOMMENDS THAT DURING ROUTINE PATIENT CARE, PHYSICIANS ASK PATIENTS AND/ OR CAREGIVERS ABOUT THE PRESENCE OF FIREARMS IN THE HOME AND COUNSEL PATIENTS WHO OWN FIREARMS ABOUT THE POTENTIAL DANGERS INHERENT IN GUN OWNERSHIP, ESPECIALLY IF CHILDREN ARE PRESENT.~~ 2013

Explanatory Statement:
The HOD Reference Committee referred this sunset policy to BSAPH in July 2018, stating that the amendment, as written, is a separate resolution (unrelated to the Tarasoff ruling) and should be resubmitted as such. BSAPH added an edited version of this statement to H406-A/14 FIREARM SAFETY which is submitted as a sunset policy for the 2019 HOD meeting.

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: CMS RULES ON PSYCHOTROPIC MEDICATIONS IN NURSING FACILITIES

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, The Centers for Medicare and Medicaid Services (CMS) has initiated several regulatory initiatives to decrease the use of antipsychotic and other psychotropic medications in Nursing Facilities (NFs); and

WHEREAS, in November of 2017, CMS announced several regulatory changes for nursing facilities including an expanded definition of psychotropic medication and new limitations on the use of as needed (PRN) psychotropic medications[(1)]; and

WHEREAS: the definition psychotropic medications now includes "any drug that affects brain activities associated with mental processes and behavior". These drugs include, but are not limited to, the following drug categories: antipsychotic, antidepressant, antianxiety, hypnotic, as well as medication classes that may affect brain activity. This expanded list of psychotropic medications includes central nervous system agents, mood stabilizers, anticonvulsants, muscle relaxants, anticholinergic medications, antihistamines, N-methyl-D- aspartate receptor modulators, and over-the-counter natural or herbal products[(1)]; and

WHEREAS: CMS has placed a 14-day limit on the duration of use of "psychotropic medications" when prescribed for PRN. For antipsychotics, a 14-day limitation is applied to all PRN orders; as a result, these orders may not be extended beyond the 14-day limit. To continue their use, a new order for the PRN antipsychotic may be written if the prescribing practitioner directly examines and assesses the resident and documents clinical rationale. This clinical rationale must include the benefit of the medication for that resident. This documentation is required every 14 days for a resident receiving a PRN antipsychotic <u>without exception, including hospice patients</u>.[(1)]; and

WHEREAS: hospice patients are often residents in a NFs, and psychotropic medications are often employed for symptom relief and comfort measures; and

WHEREAS: CMS rules requiring repeated direct examination, re-documentation of clinical rationale, and re-ordering of medication which can result in delayed treatment or care; and

WHEREAS, osteopathic physicians desire to ensure our patients receive the care they need in a timely manner; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) petition The Centers For Medicare And Medicaid Services (CMS) to exclude hospice patients from the CMS rules for use of psychotropic and antipsychotic medication in NFs; and, be it further

RESOLVED, that the AOA work with CMS to refine the rules governing the PRN use of antipsychotic and **OTHER** psychotropic medications **FOR ANY NURSING FACILITY PATIENT** to improve the continuity of patient care, decrease costs, and ease physician burden, based on scientific evidence and valid clinical studies.

References:

1. Centers for Medicare & Medicaid Services (CMS). Revision to State Operations Manual (SOM) appendix PP for phase 2, F-tag revisions, and related issues, Section F757. CMS website. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf. Accessed November 10, 2017.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: OPPOSITION TO PATIENT DISCRIMINATION OF OSTEOPATHIC PHYSICIANS BECAUSE OF RACE, COLOR, RELIGION, GENDER, SEXUAL ORIENTATION, GENDER IDENTITY OR NATIONAL ORIGIN

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, the American Osteopathic Association (AOA) has historically taken a strong position against osteopathic physicians discriminating against patients because of, but not limited to their race, color, religion, gender, sexual orientation, gender identity or national origin; and

WHEREAS, the AOA Code of Ethics assures that patients have autonomy and freedom of choice when selecting an osteopathic physician; and

WHEREAS, some patients have refused to allow a physician treat them based solely on the physician's race, color, religion, gender, sexual orientation, gender identity or national origin; and

WHEREAS, physicians have no similar protections against patients refusing to receive care from a physician due to the physician's race, color, creed, religion, gender, sexual orientation, gender identity or national origin; and

WHEREAS, this discrimination is an abuse and misinterpretation by the patient of their protected autonomy; and

WHEREAS, physicians, especially those in areas with limited physician availability may be called upon to treat a patient who has previously declined to be treated by a particular physician are compelled by medical ethics to provide emergency treatment to these patients; and

WHEREAS, without the intervention of these physicians, the patient would be at great risk of loss of life or limb; and

WHEREAS, physicians acting in these situations place themselves at significant risk of being accused of acting unethically; and

WHEREAS, the AOA has no statement supporting these physicians in providing life or limb saving treatment despite the patient expressing a desire not to be treated by the physician due solely to the physician's race, color, religion, gender, sexual orientation, gender identity or national origin; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) deems it ethical for osteopathic physicians to provide care to a patient in LIFE THREATENING

EMERGENCIES even when the patient has refused treatment from the physician because of the physician's race, color, religion, gender, sexual orientation, gender identity or national origin; and, be it further

RESOLVED, that the American Osteopathic Association (AOA) supports the education of the public that osteopathic physicians should be evaluated by their skill and knowledge rather than by race, color, religion, gender sexual orientation, gender identity or national origin.

Reference Committee Explanatory Statement:
The Committee believes that the content in this resolution violates the Patient's Bill of Rights and state laws that address this issue vary.

ACTION TAKEN **REFERRED** *(to the Iowa Osteopathic Medical Association)*

DATE **July 27, 2019**

SUBJECT: RECOGNITION OF HEALTH CARE AS A HUMAN RIGHT

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, the World Health Organization recognizes "the highest attainable standard of health as a fundamental right of every human being," and states "the right to health includes access to timely, acceptable, and affordable health care of appropriate quality"[1]; and

WHEREAS, the United States ranks 33rd out of 34 countries in the Organization for Economic Co-operation and Development (OECD) in percentage of insured population (with 88.5%), with nearly every other country at > 98%[2]; and

WHEREAS, 25-30 million Americans are still uninsured after implementation of the Affordable Care Act (ACA), and the non-partisan Congressional Budget Office estimates that this number would increase to 48 million, and continue to increase annually, with an ACA repeal[3]; now, therefore, be it

RESOLVED, that the American Osteopathic Association recognizes that health care is a human right for every person[4], not a privilege.

References:

1. World Health Organization Media Center. "Health and Human Rights." Fact Sheet N°232, Dec 2015. Accessed Feb 2017. http://www.who.int/mediacentre/factsheets/fs323/en/
2. OECD (2015), Health at a Glance 2015: OECD Indicators, OECD Publishing, Paris. http://dx.doi.org/10.1787/health_glance-2015-en
3. Congressional Budget Office. "How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums." Jan 2017. https://www.cbo.gov/publication/52371
4. Bauchner, H. "Health Care in the United States: A Right or a Privilege." JAMA. 2017; 317(1):29. http://jamanetwork.com/journals/jama/fullarticle/2595503 - Journal of the American Medical Association (JAMA), the editor-in-chief of JAMA voiced a hope that all physicians and professional societies will "speak with a single voice and say that health care is a basic right for every person, and not a privilege to be available and affordable only for a majority."

Reference Committee Explanatory Statement:
The committee believes that the resolution, as written, lacks clarity and direction.

ACTION TAKEN **REFERRED** *(to the Michigan Osteopathic Medical Association)*

DATE **July 27, 2019**

SUBJECT: OSTEOPATHIC PHYSICIANS AND THE AVAILABILITY OF NALOXONE

SUBMITTED BY: Ohio Osteopathic Association

REFERRED TO: Committee on Public Affairs

WHEREAS, opioid deaths are at epidemic proportion. In 2017, the number of overdose deaths involving opioids was six times higher than in 1999; and

WHEREAS, on average 130 Americans die every day from an opioid overdose; and

WHEREAS, rapid administration of naloxone can potentially reverse the effects of opioid overdose; and

WHEREAS, studies have shown naloxone administration by bystanders significantly improves the odds of recovery compared to no naloxone administration; now, therefore be it

RESOLVED, that physicians discuss naloxone and how to obtain it with their patients and patients' families, struggling with opioid addiction, and encourage them to have these kits available at all times.

Explanatory Statement:

References:

(ref. Wide-ranging online data for epidemiological research (WONDER). Atlantic, Ga.: CDC, National Center for Health Statistics; 2017.

(ref. Effectiveness of bystander naloxone administration and overdose education programs: a meta-analysis, Rebecca Giglio, et al. Injury Epidemiology. 2015 Dec: 2(1): 10.

Reference Committee Explanatory Statement

The Committee believes this resolution is covered under H632 A/18.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: PHYSICIAN AWARENESS OF FIREARM SAFETY IN OLDER PERSONS

SUBMITTED BY: Pennsylvania Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, in 2016, gun violence in America was declared a public health crisis; and

WHEREAS, there have been 4.2 deaths every day due to gun violence in the Commonwealth of Pennsylvania; and

WHEREAS, 27% of adults older than 65 years of age own one or more firearms and more than 37% reside in a home where a firearm is present; and

WHEREAS, it is estimated that older individuals are those most likely to develop vision and hearing loss, dementia, physical disability and other conditions incompatible with safe firearm us; and

WHEREAS, males over age 65 are the group most likely to successfully complete suicide using a firearm; and

WHEREAS, under federal law a person suffering from mental illness is not prohibited from purchasing a firearm unless they have been committed to a mental institution; and

WHEREAS, there are numerous reports of innocent individuals, including loved ones and caregivers, who have been unintentionally or mistakenly injured or killed at the hands of an older person; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) develop materials to ensure physicians are made fully aware of the staggering statistics of the gun crisis in American as related to the population of older individuals; and be it further

RESOLVED, that AOA develop educational programs to ensure that physicians are taught about the importance of asking questions about firearm safety as part of clinical responsibility; and, be it further

RESOLVED, that AOA develop or partner with appropriate groups to provide appropriate screening tools regarding firearm safety; and, be it further

RESOLVED, that the AOA encourage discussion regarding gun safety so that it is viewed by physicians as a routine part of health care for older adults and vulnerable persons.

Explanatory Statement:

For more than 20 years, the American College of Physicians (ACP) has advocated for the need to address firearm-related injuries and deaths in the United States. Yet, firearm violence continues to be a public health crisis that requires the nation's immediate attention. The policy recommendations in this

paper *Reducing Firearm Injuries and Deaths in the United States: A Position Paper from the American College of Physicians* build on, strengthen, and expand current ACP policies approved by the Board of Regents in April 2014, based on analysis of approaches that the evidence suggests will be effective in reducing deaths and injuries from firearm-related violence

The following physician associations - American College of Surgeons, American College of Obstetricians and Gynecologists, American Public Health Association, American Psychiatric Association, American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, and American Bar Association supported a call to action to address gun violence as a public health threat, which was subsequently endorsed by 52 additional organizations that included clinician organizations, consumer organizations, organizations representing families of gun violence victims, research organizations, public health organizations, and other health advocacy organizations.

The position paper is attached for your consideration.

Reference Committee Explanatory Statement
This subject is addressed in H-425. Additionally, the white paper only addresses individuals with dementia; it does not specifically address older persons.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: OPPOSING ZERO-TOLERANCE IMMIGRATION POLICIES AND THE SEPARATION OF FAMILIES AT THE BORDER

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, a zero-tolerance immigration policy is defined as the immediate prosecution and detention of adults entering the country illegally, without exception for those seeking asylum or accompanied by minors;[1] and

WHEREAS, zero-tolerance immigration policies have the added effect of separating children from their families at the time of detention;[1] and

WHEREAS, according to the American Academy of Pediatrics in 2017, the basic standards of care for immigrant children in detention in the US were not met; specifically there were "egregious conditions in processing centers included inadequate bathing and toilet facilities, constant light exposure, children sleeping on concrete floors, confiscation of belongings, insufficient food, denial of access to thorough medical care, lack of mental health support plus physical and emotional maltreatment;" [2] and

WHEREAS, children accumulating Adverse Childhood Experiences (ACEs), such as the trauma of being separated from their families and being placed in separate detention centers that do not adequately meet their basic needs, experience increased risks of cancer, heart disease, mental health disorders, other diseases, and early death[1, 4, 5]; and

WHEREAS, separation of families fleeing persecution in their home countries led to an increase in depression/anxiety and posttraumatic stress disorder[6] ;and

WHEREAS, there is evidence that this separation from their families can damage the children's attachment relationships, cause toxic stress, and even led to greater health disparities[1]; and

WHEREAS, alternative approaches to detention centers exist and are more humane and less expensive[3]; and

WHEREAS, there is no empirical evidence to demonstrate that threats of detainment deter individuals from seeking asylum[7]; and

WHEREAS, statements condemning the separation of immigrant families have already been issued by the Royal College of Pediatrics and Child Health, the American Academy of Pediatrics, the Canadian Pediatric Society, the American Medical Association, the Canadian Medical Association, and the International Society for Social Pediatrics & Child Health[6]; and

WHEREAS, according to the American Osteopathic Association's code of ethics, section 13, "A physician shall respect the law. When necessary a physician shall attempt to help to formulate the law by all proper means in order to improve patient care and public health"[8]; now, therefore be it,

RESOLVED, that the American Osteopathic Association (AOA) oppose zero-tolerance immigration policies, especially policies where children are separated from their families; and, be it further

RESOLVED, that the AOA act to discourage existing and future efforts to create, enforce, or legislate similar zero-tolerance immigration policies.

References

1. Wood, L.C.N. (2018). Impact of punitive immigration policies, parent-child separation and child detention on the mental health and development of children. BMJ Paediatrics Open, 2 (1). Retrieved from: doi:10.1136/bmjpo-2018-000338
2. Linton, J., Griffin, M., Shapiro, A. (2017) Detention of Immigrant Children. Retrieved from: http://pediatrics.aappublications.org/content/139/5/e20170483.long.
3. A Guide to Children Arriving at the Border: Laws, Policies and Responses. In (June 2015 ed.). American Immigration Council.
4. Felitti, V.J., Anda, R.F., Nordenberg, D., et al (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventative Medicine, 14(4), 245-258.
5. About Adverse Childhood Experiences. https://www.cdc.gov/violenceprevention/acestudy/about_ace.html. Accessed January 31, 2019.
6. Miller, A., Hess, J.M., Bybee, D., et al (2019). Understanding the mental health consequences of family separation for refugees: Implications for policy and practice. American Journal of Orthospychiatry, 88(1), 26-37.
7. There are alternatives: A handbook for preventing unnecessary immigration detention. (2015). International Detention Coalition.
8. American Osteopathic Association Code of Ethics. (July 24, 2016). Retrieved from https://osteopathic.org/about/leadership/aoa-governance-documents/code-of-ethics/

Reference Committee Explanatory Statement

The Committee believes the resolution does not focus actionable healthcare issues.

ACTION TAKEN **DISAPPROVED**

DATE **July 27, 2019**

SUBJECT: RECOGNIZING FOOD INSECURITY AS A PUBLIC HEALTH ISSUE

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

WHEREAS, food insecurity is defined as "the disruption of food intake or eating patterns because of lack of money and other resources"[1]; and

WHEREAS, the United States Department of Agriculture (USDA) has reported that 11.8 percent (15 million) of U.S. households experienced food insecurity during 2017[2]; and

WHEREAS, in 2017[2] food insecurity was inequitably experienced at high rates in households with children headed by single women (30.3 percent), Black (non-Hispanic) households (21.8 percent), Hispanic households (18 percent), and households with children headed by a single man (19.7 percent); and

WHEREAS, scientific literature has "consistently found food insecurity to be negatively associated with health outcomes" including increased likelihood of childhood asthma and earlier onset of limitations in activities of daily living for seniors[3]; and

WHEREAS, a constitutional objective of the American Osteopathic Association is to "to promote the public health"; now, therefore be it,

RESOLVED, that the American Osteopathic Association recognizes food insecurity as a public health issue.

References

1. U.S. Department of Human and Health Services: Office of Disease Prevention and Health Promotion. (2019, February 11). Food Insecurity. Retrieved February 11, 2019, from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/food-insecurity
2. Alisha Coleman-Jensen, Matthew P. Rabbitt, Christian A. Gregory, and Anita Singh. 2018. Household Food Security in the United States in 2017, ERR-256, U.S. Department of Agriculture, Economic Research Service.
3. Gundersen, C., & Ziliak, J. P. (2015). Food Insecurity And Health Outcomes. Health Affairs, 34(11), 1830–1839. https://doi.org/10.1377/hlthaff.2015.0645

ACTION TAKEN **APPROVED**

DATE **July 27, 2019**

SUBJECT: COMMUNITY PHARMACIES; REQUIRED NOTIFICATION OF PRIMARY CARE PROVIDERS REGARDING VACCINATION ADMINISTRATION

SUBMITTED BY: Illinois Osteopathic Medical Society

REFERRED TO: Committee on Public Affairs

WHEREAS, immunizations currently prevent between 2 – 3 million deaths each year worldwide; and

WHEREAS, an additional 1.5 million deaths could be avoided with improved vaccination rates worldwide; and

WHEREAS, vaccines not only provide individual protection for those persons who are vaccinated, they also provide community protection by reducing the spread of disease within a population; and

WHEREAS, physicians and patient care providers have a responsibility/duty to promote immunizations to all eligible people for vaccine preventable illnesses; and

WHEREAS, **IN SOME STATES** vaccinations can be administered by pharmacists educated in the practice of immunization delivery; and

WHEREAS, community pharmacies provide a convenient and accessible option for people to receive needed immunizations; now, therefore be it

RESOLVED, that the American Osteopathic Association support measures that would require pharmacists to provide documentation of immunizations, administered in the community-based pharmacy setting, to the patient's primary care physician **IN APPROPRIATE REGISTRIES**.

Explanatory Statement:

Requiring pharmacists and/or delegated pharmacy technicians at community based pharmacies to provide documentation of immunizations administered to patients directly to their primary care provider would reduce the number of duplicate vaccinations received by patients, enhance provider awareness and readiness to assist patients experiencing vaccine-related adverse events, and increase appropriate reporting of vaccine-related events in the Vaccine Adverse Event Reporting System (VAERS) by primary care providers.

References

1. 10 facts on immunization. (2018, March). Retrieved from World Health Organization: https://www.who.int/features/factfiles/immunization/en/
2. Bach, A. a. (2015, July 1). The role of community pharmacy-based vaccination in the USA: current practice and future directions. Integrated Pharmacy Research and Practice, pp. 67 - 77.

3. Orenstein, W. a. (2017, April 10). Simply put: Vaccination saves lives. Proceedings of the National Academy of Sciences of the United States of America, pp. 114 - 116.
4. Vaccines & Immunizations: What Would Happen If We Stopped Vaccinations? (2018, June 29). Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/vaccines/vac-gen/whatifstop.htm

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**

SUBJECT: FIREARM VIOLENCE

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Committee on Public Affairs

~~**WHEREAS, nearly two-thirds of deaths by firearm are related to suicide; and**~~

~~**WHEREAS, of the remaining one-third of firearm deaths 83% are related to gangs or the drug trade; and**~~

~~**WHEREAS, the right to keep and bear arms is a constitutionally protected right; and**~~

~~**WHEREAS, legally owned firearms are used for self-defense 2.4 million times per year, much more than they are used for suicide or to commit crimes; and**~~

WHEREAS, current American Osteopathic Association (AOA) firearm violence policy is represented by ~~**9 separate**~~ **MULTIPLE** policies, several of which are due for sunset review in 2020; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) develop a comprehensive policy which consolidates all current firearm violence policies into a single unified policy ~~**that addresses the core causes of violence and the criminality associated, as well as the mental health issues associated with suicide while upholding the civil rights of law abiding citizens**~~; and, be it further

RESOLVED, that the American Osteopathic Association (AOA) present it for consideration by the 2020 AOA House of Delegates.

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 27, 2019**