House of Delegates Policies

2020 - 2024

AMERICAN OSTEOPATHIC ASSOCIATION

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SPECIAL MEETING OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
EDUCATIONAL AFFAIRS - RESOLUTION ROSTER
As of September 7, 2020

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:

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

Res. No.	Resolution Title	Submitted By	Reference Committee
H200	Graduate Medical Education – Training of US Medical School Graduates (H213-A/15)	BOE	Education
H201	Rural Sites – Osteopathic Education in (H214-A/15)	BOE	Education
H202	Directors of Medical Education Overseeing Osteopathic Postdoctoral Training Programs (H216-A/15)	BOE	Education
H203	Autopsies (H217-A/15)	BOE	Education
H204	Clarity Regarding Matching Service Listing of AOA Residencies with ACGME Pre-Accreditation Status (H219-A/15)	BOE	Education
H205	Blue Ribbon Commission Report (H223-A/15)	BOE	Education
H206	AOA to Support Education and Advocate for Policies Relating to Climate Change	MOA	Education
H207	Adoption of Specific Informed Consent Guideline for Sensitive Exams Under Anesthesia for Education Purposes	SOMA	Education
H208	Incorporating Continuing Medical Education Opportunities on Human Trafficking	SOMA	Education
H209	Incorporating Continued Medical Education Regarding Intellectual and Developmental Disabilities	SOMA	Education
H210	Recommendation of Buprenorphine Waiver Training in Osteopathic Medical Schools	BSAPH	Education
H211	Referred Res. No H-224 – A/2019 AOA Board Certification Terminology	BOS	Education
H212	Residency Redistribution of Center for Medicare/Medicaid Services Funding Following Single Accreditation Systems (SAS)	OPSC	Education
H213	Training High Quality Physicians in a Healthy and Safe Environment	MAOP	Education
H214	Audition Rotations for Osteopathic Medical Students	IOMA	Education

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
EDUCATIONAL AFFAIRS (200 SERIES)

House Of Delegates' Reference Committee Description:
Committee on Educational Affairs (200 series)
This reference committee reviews and considers matters relating to osteopathic education, osteopathic colleges, and postdoctoral training.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-200	Maintenance of Primary Board Certification for Subspecialty Certification	AOAAM	Educational Affairs	NOT ADOPTED
H-201	Vital Nature of Board-Certified Physicians in Aerospace Medicine	AOCOPM	Educational Affairs	ADOPTED as AMENDED
H-202	~~Training High Quality Physicians in a Healthy and Safe Environment~~ - WITHDRAWN BY AUTHOR	MAOP	Educational Affairs	WITHDRAWN
H-203	Physician Designation, Truth in Advertising and Residency/Fellowship Training Non-Physician Post-Graduate Medical Training	NYSOMS	Educational Affairs	ADOPTED as AMENDED
H-204	Protective Educational Environments for Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning Youth	OOA	Educational Affairs	ADOPTED as AMENDED
H-205	Resolution Withdrawn			
H-206	Optional Correct Pronoun Demographic on General Medical Education Applications	BEL	Educational Affairs	ADOPTED
H-207	Referred Res. No. H-219 – A/2019 Osteopathic Manipulative Treatment Boot Camp	BOS	Educational Affairs	ADOPTED as AMENDED
H-208	~~Osteopathic Board Payment Reform~~ WITHDRAWN BY UNANIMOUS CONSENT	MOA	Educational Affairs	WITHDRAWN
H-209	Restoring An Equitable and Positive Learning Environment in Medical Training	MOA	Educational Affairs	REFERRED TO AUTHOR
H-210	Access To Healthcare-Developing a New Model of Administering Osteopathic Primary Care in the U.S. (SR-Source: H201-A-16)	BOE	Educational Affairs	ADOPTED

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
EDUCATIONAL AFFAIRS (200 SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-211	~~Depression~~ ACCESS TO MENTAL HEALTH SERVICES AND Awareness in U.S. OSTEOPATHIC Medical Students (SR-Source: H203-A/16)	BOE	Educational Affairs	ADOPTED as AMENDED
H-212	Disaster Response ~~Courses and~~ Training ~~Within Colleges of Osteopathic Medicine~~ (SR-Source: H204-A/16)	BOE	Educational Affairs	ADOPTED as AMENDED
H-213	Academic Osteopathic Educators, Researchers or Administrators Educational Program Development (SR-Source: H205-A/16)	BOE	Educational Affairs	ADOPTED (SUNSET)
H-214	Uniform Title for Osteopathic Medical Students (SR-Source: H208-A/16)	BOE	Educational Affairs	ADOPTED
H-215	Tobacco Free AND VAPING FREE Colleges / Schools of Osteopathic Medicine (SR-Source: H209-A/16)	BORPH	Educational Affairs	ADOPTED as AMENDED
H-216	Rural Healthcare Provided by Current ~~AOA~~ GME Programs – Preservation of (SR-Source: H211-A/16)	BOE	Educational Affairs	ADOPTED as AMENDED
H-217	Drug Stimulant Abuse in the Academic Setting – Education and Resources for (SR-Source: H213-A/16)	BOE	Educational Affairs	ADOPTED
H-218	Graduate Medical Education Funding and Incentives (SR-Source: H329-A/16)	CERA/BFH/ CSHA	Educational Affairs	ADOPTED
H-219	Promotion Of Osteopathic Medicine to Disadvantaged High School Students (SR-Source: H402-A/16)	BORPH	Educational Affairs	ADOPTED
H-220	Residency Training in Canada – Equality Between COCA- Accredited and LCME-Accredited Medical School Graduates Seeking (SR-Source: H641-A/16)	BOE	Educational Affairs	ADOPTED

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102nd ANNUAL AOA HOUSE OF DELEGATES
JULY 17, 2022, MEETING
RESOLUTION ROSTER (200 SERIES)

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:
Committee on Educational Affairs (200 series)
This reference committee reviews and considers matters relating to osteopathic education, osteopathic colleges, and postdoctoral training.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-200	Ensuring that Graduate Medical Education (GME) Programs Continue to Select Residents Based on Merit (SR- Source: H200-A/17)	BOE	Educational Affairs	Adopted as Amended
H-201	Ambulatory-Based Primary Care Residency Programs (SR- Source: H201-A/17)	BOE	Educational Affairs	Adopted
H-202	Joining Forces Initiative (SR- Source: H205-A/17)	BOE	Educational Affairs	Adopted
H-203	Disability Determinations (SR- Source: H206-A/17)	BOE	Educational Affairs	Adopted as Amended
H-204	Non-Gender Discrimination (SR - Source : H207-A/17)	BOE	Educational Affairs	Adopted for Sunset
H-205	Supervision for Osteopathic Manipulative Treatment (SR- Source: H209-A/17)	BOE	Educational Affairs	Adopted
H-206	Training Reaffirmation of Primary Care Physicians (SR - Source: H210-A/17)	BOE	Educational Affairs	Adopted as Amended
H-207	Clearly Articulated Protocol for Sleep Facilities and Safe Transportation in All Physician Residencies (SR- Source: H213-A/17)	BOE	Educational Affairs	Adopted for Sunset
H-208	Longitudinal Approach to Cultural Competency Dialogue on Eliminating Health Care Disparities (SR - Source: H215-A/17)	BOE	Educational Affairs	Adopted as Amended
H-209	United States Immigration Executive Order Impact on Medical Education (SR-Source: H222-A/17)	BOE	Educational Affairs	Adopted
H-210	Importance of Empathy in Osteopathic Medical Education and Practice (SR- Source: H226-A/17)	BOE	Educational Affairs	Adopted as Amended
H-211	Equivalency Policy for Osteopathic Continuous Certification (SR- Source: H227-A/17)	BOS	Educational Affairs	Adopted
H-212	Loan Deferment During Residency (SR - Source: H202-A/17)	BFHP	Educational Affairs	Adopted

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102nd ANNUAL AOA HOUSE OF DELEGATES
JULY 17, 2022, MEETING
RESOLUTION ROSTER (200 SERIES)

H-213	Osteopathic Licensing (SR - Source: H208-A/17)	CSHA	Educational Affairs	Adopted
H-214	Osteopathically Recognized Graduate Medical Education Programs (SR - Source: H212-A/17)	BFHP	Educational Affairs	Adopted as Amended
H-215	Promoting Osteopathic Principles and Practices (OPP) in Continuing Medical Education (CME)	MOMA	Educational Affairs	Referred
H-216	Osteopathic Principles and Practices (OPP) and Educational Efforts to Incorporate Value-Based Care in All Levels of Osteopathic Medical Education	MOMA	Educational Affairs	Referred
H-217	Equality In Away Rotations/Sub-Internships for Osteopathic Medical Students	BEL	Educational Affairs	Adopted as Amended
H-218	Maintenance of Primary Board Certification for Subspecialty Certification	AOAAM	Educational Affairs	Disapproved
H-219	ABIM Board Eligibility	OPSC	Educational Affairs	Adopted as Amended
H-220	Physician Designation, Truth in Advertising and Residency/Fellowship Training Non-Physician Post Graduate Medical Training 2022	NYSOMS	Educational Affairs	Adopted as Amended
H-221	WITHDRAWN BY AUTHOR			
H-222	WITHDRAWN BY AUTHOR			
H-223	Osteopathic Education	IOMA	Educational Affairs	Adopted as Amended

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103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (200 SERIES) w/ACTION
As of 07-24-23

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:
Committee on Educational Affairs (200 series)
This reference committee reviews and considers matters relating to osteopathic education, osteopathic colleges, and postdoctoral training.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-200	Develop and Implement Curriculum on the Care of People with Developmental Disabilities (SR-Source:H211-A/18)	BOE	Educational Affairs	Adopted
H-201	DO Degree Designation (SR–Source:H204-A/18)	BOE	Educational Affairs	Adopted as Amended
H-202	Osteopathic Manipulative Treatment (OMT) by Osteopathic Medical Students During Medical School Rotations, Promoting use of (SR-Source:H200-A/18)	BOE	Educational Affairs	Adopted as Amended
H-203	Osteopathic Postdoctoral Training in all Specialty Areas (SR–Source:H202-A/18)	BOE	Educational Affairs	Adopted as Amended
H-204	Peer-To-Peer Suicide Prevention Training Amongst Osteopathic Medical Schools (SR-Source:H212-A/18)	BOE	Educational Affairs	Adopted as Amended
H-205	Sex and Gender Based Medicine (SR-Source:H214-A/18)	BOE	Educational Affairs	Adopted as Amended
H-206	Sale of Health-Related Products and Devices (SR-Source:H209-A/18)	BOM	Educational Affairs	Adopted as Amended
H-207	Acupuncture (SR-Source:H207-A/18)	BORPH	Educational Affairs	Adopted
H-208	Osteopathic Continuous Certification-Affordability of (SR–Source:H210-A/18)	BOS	Educational Affairs	Adopted as Amended
H-209	Osteopathic Continuous Certification (SR-Source:H208-A/18)	CSHA	Educational Affairs	Adopted
H-210	Truth in Advertising – Physician Degrees (SR-Source:H206-A/18)	CSHA	Educational Affairs	Adopted as Amended
H-211	Exploring the Impact of Virtual Residency Interviews on Osteopathic Residency Match Rate	BEL	Educational Affairs	Adopted as Amended
H-212	Marketing AOA Board Certification	AOCOPM	Educational Affairs	Adopted as Amended
H-213	American Osteopathic Association Board Certification	IOMA	Educational Affairs	Not Adopted
H-214	Support for Inclusion of Osteopathic Residency Applicants in Surgical Training	OPSC/ ACOS	Educational Affairs	Adopted as Amended

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (200 SERIES) W/ACTION
As of 07-22-24

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTION:
Committee on Educational Affairs (200 series)
This reference committee reviews and considers matters relating to osteopathic education, osteopathic colleges, and postdoctoral training.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-200	Mandatory CME Course Requirements (SR-Source-H211-A/19)	BFHP	Educational Affairs	Adopted as Amended
H-201	Health Care Shortage in Rural America (SR-Source-H200-A/19)	BOE	Educational Affairs	Adopted as Amended
H-202	Graduate Medical Education – Increasing Opportunities (SR-Source-H201-A/19)	BOE	Educational Affairs	Adopted
H-203	Uniformed Services Physicians Requiring and Assigned to Civilian Residency Programs – AOA Support of All Osteopathically Trained (SR-Source-H204-A/19)	BOE	Educational Affairs	Adopted
H-204	Integrity and Mission of COMs UHSC Granting the DO – Maintaining the (SR-Source-H208-A/19)	BOE	Educational Affairs	Adopted
H-205	Psychiatry Curriculum and Staffing (SR-Source-H209-A/19)	BOE	Educational Affairs	Adopted as Amended
H-206	Community-Based Teaching Health Centers Residency Support (SR-Source-H212-A/19)	BOE	Educational Affairs	Adopted
H-207	Influenza Vaccination Programs for Medical Schools (SR-Source-H214-A/19)	BOE	Educational Affairs	Adopted as Amended
H-208	American Osteopathic Association Specialty Board Certification (SR-Source-H220-A/19)	BOE	Educational Affairs	Adopted as Amended
H-209	Education of Students and Faculty on Obtaining Permission Before All Student and Patient Encounters (SR-Source-H223-A/19)	BOE	Educational Affairs	Adopted
H-210	Classification of Osteopathic Medical Graduates as US Medical Graduates in Electronic Residency Application Service (SR-Source-H230-A/19)	BOE	Educational Affairs	Referred to BOE
H-211	Teenage Alcohol Abuse (SR-Source-H210-A/19)	BORPH	Educational Affairs	Adopted as Amended
H-212	Inhalation of Volatile Substances (SR-Source-H207-A19)	BORPH	Educational Affairs	Adopted as Amended

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (200 SERIES) W/ACTION
As of 07-22-24

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-213	Clinical Rotations for International Medical Students (SR-Source-H206-A/19)	CSHA	Educational Affairs	Adopted as Amended
H-214	AOA Recognition of the American College of Osteopathic Pediatricians (ACOP) and American Osteopathic Board of Pediatricians (AOBP)	ACOP	Educational Affairs	Adopted as Amended
H-215	Assessing the Impact of Alternative Match Processes on Osteopathic Student Residency Placement Rates	BEL	Educational Affairs	Adopted as Amended
H-216	Interdisciplinary Education and High Value Care	MOMA (Montana)	Educational Affairs	Referred to BOE
H-217	Support for Increasing Access to Training Opportunities in American Indian and Alaska Native Communities	OOA (Oklahoma)	Educational Affairs	Adopted as Amended
H-218	Support for the Creation of Specialty and Sub-Specialty Osteopathic Recognition Training Exams	OOA (Ohio)	Educational Affairs	Adopted as Amended
H-219	Support of the Physical Exam in Education and Practice	OOA (Ohio)	Educational Affairs	Adopted as Amended
H-220	Osteopathic Undergraduate Education Core Competencies	POMA/WOMA (Pennsylvania/ Washington)		Withdrawn
H-221	Resolution on Credential Requirements for Presidents and Leaders of Osteopathic Medical Specialty Board Societies	WAOPS (Wisconsin)	Educational Affairs	Adopted as Amended
H-222	Importance of Accredited Training and Board Certification in Aerospace Medicine for the Growing Commercial Space Industry	AOCOPM	Educational Affairs	Adopted as Amended
H-223	Certifying Board Services Workgroup Report (Policy H212-A/23 Promotion of AOA Board Certification)	AOA BOT	Educational Affairs	Adopted as Amended
H-224	Value of Osteopathic Medical School Education	MAOP (Maryland)	Educational Affairs	Referred to BOE

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Graduate Medical Education – Training of US Medical School Graduates

Policy Statement

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

Source: H200-A/20

Status: 2009; 2014 Referred; 2015 Reaffirmed as Amended; 2020 Reaffirmed

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Rural Sites – Osteopathic Education in

Policy Statement

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

Source: H201-A/20

Status: 1990; 1995 Reaffirmed as Amended; 2000 Reaffirmed; 2005 Reaffirmed; 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

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Directors of Medical Education Overseeing Osteopathic Postdoctoral Training Programs

Policy Statement

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

Source: H202-A/20

Status: 2010, 2015 Reaffirmed; 2020 Reaffirmed as Amended

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Autopsies

Policy Statement

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

Source: H203-A/20

Status: 2010; 2015 Reaffirmed; 2020 Reaffirmed

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Blue Ribbon Commission Report

Policy Statement

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

Source: H205-A/20

Status: 2015; 2020 Reaffirmed

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Incorporating Continued Medical Education Regarding Intellectual and Developmental Disabilities

Policy Statement

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

Source: H209-A/20

Status: 2020 Reaffirmed as Amended

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Audition Rotations for Osteopathic Medical Students

Policy Statement

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

Source: H214-A/20

Status: 2020 Adopted as Amended

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Vital Nature of Board-Certified Physicians in Aerospace Medicine

Policy Statement

The American Osteopathic Association recognizes the unique contributions and advanced qualifications of Aerospace Medicine professionals; and specifically opposes any and all efforts to remove, reduce or replace Aerospace Medicine physician leadership in civilian, corporate or government Aerospace Medicine programs and aircrew healthcare support teams. The AOA will advocate against further Aerospace medicine mid-level provider scope of practice expansions that threaten the safety, health, and wellbeing of aircrew, patients, support personnel and the flying public.

Source: H201-A/21

Status: 2021

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Physician Designation, Truth in Advertising and Residency/Fellowship Training Non-Physician Post-Graduate Medical Training

Policy Statement

When the American Osteopathic Association (AOA) utilizes the term, “physician,” it is to mean, “DO or MD or a recognized international equivalent terminal degree in medicine,” and be used exclusively by graduates from educational programs provided by a college of osteopathic medicine or allopathic medicine accredited by the Commission on Osteopathic College Accreditation or the Liaison Committee on Medical Education leading to the DO or MD degree, or recognized international equivalent terminal degree in medicine. The AOA will work with the American Medical Association (AMA), and other relevant stakeholders to continue to advocate that the title of Physician Assistant (PA) be preserved, and that the proposed title change to “Physician Associate” be rejected, because the proposed use of “associate” is misleading and should be abandoned out of concern for the potential impact on patient care and safety.

Source: H203-A/21

Status: 2021

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Protective Educational Environments for Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning Youth

Policy Statement

The American Osteopathic Association recognizes the importance and supports advocacy that acknowledge LGBTQ identities, and the implementation of anti-bullying policies that specifically protect children from harassment based on sexual orientation or gender identity in educational settings.

Source: H204-A/21

Status: 2021

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Protective Educational Environments for Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning Youth

Policy Statement

The American Osteopathic Association recognizes the importance and supports advocacy that acknowledge LGBTQ identities, and the implementation of anti-bullying policies that specifically protect children from harassment based on sexual orientation or gender identity in educational settings.

Source: H206-A/21

Status: 2021

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Access to Mental Health Services and Awareness in U.S. Osteopathic Medical Students

Policy Statement

The American Osteopathic Association recommends that there be increased mental health awareness amongst U.S. osteopathic medical students and that treatment options be available that are accessible, private and confidential for those affected.

Source: H211-A/21

Status: 2011; 2016 Reaffirmed; 2021 Reaffirmed as Amended

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Disaster Response Training

Policy Statement

The American Osteopathic Association encourages disaster response training for osteopathic physicians and students.

Source: H212-A/21

Status: 2011; 2016 Reaffirmed; 2021 Reaffirmed as amended.

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Uniform Title for Osteopathic Medical Students

Policy Statement

The American Osteopathic Association recommends that students enrolled in accredited osteopathic medical schools be referred to as Osteopathic Medical Students (OMS); after the letters OMS, the level of study be identified by Roman Numerals I, II, III, and IV, and V, etc., such as OMS I, OMS II, OMS III, and OMS IV, and OMS V, etc.; unless prohibited by the institution in which they are doing a clinical rotation, students shall be identified by use of the OMS and appropriate Roman Numeral designation after their name (e.g., Jane Doe, OMS II, John Doe, OMS IV, etc.).

Source: H214-A/21

Status: 2006, 2011 Reaffirmed as amended; 2016 Reaffirmed; 2021 Reaffirmed

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Tobacco Free and Vaping Free Colleges / Schools of Osteopathic Medicine

Policy Statement

The American Osteopathic Association commits to the goal of establishing and supporting tobacco-free and vaping-free colleges of osteopathic medicine at every Commission on Osteopathic College Accreditation (COCA) accredited colleges of osteopathic medicine.

Source: H215-A/21

Status: 2011; 2016 Reaffirmed as amended; 2021 Reaffirmed as amended.

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Rural Healthcare Provided by Current GME Programs - Preservation of

Policy Statement

It is a priority of the American Osteopathic Association (AOA) to advocate for the development and preservation of residencies in rural and underserved communities.

Source: H216-A/21

Status: 2016; 2021 Reaffirmed as amended.

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Stimulant Abuse in The Academic Setting - Education and Resources for

Policy Statement

The American Osteopathic Association (AOA) will encourage the development of continuing medical education (CME) for physicians to recognize risk factors, ensure appropriate diagnosis, and subsequence treatment of conditions which utilize stimulants for academic performance which may be abused.

Source: H217-A/21

Status: 2016; 2021 Reaffirmed as amended.

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Graduate Medical Education Funding and Incentives

Policy Statement

The American Osteopathic Association (AOA) opposes cuts to graduate medical education (GME) funding for physician training (DO and MD); supports the distribution of federal funds for GME, prioritizing areas most in need for physician training (DO and MD) programs based upon geography and specialty; advocates for continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME; supports allowing health insurers who provide financial support for expansion or continuation of existing GME programs to include such sums as direct medical expenditures as part of the calculation of the Medical Loss Ratio of their health plans.

Source: H218-A/21

Status: 2016; 2021 Reaffirmed as amended.

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Promotion of Osteopathic Medicine to Disadvantaged High School Students

Policy Statement

The American Osteopathic Association encourages colleges of osteopathic medicine to identify and support outreach programs for disadvantaged high school students in their communities for successful health careers in osteopathic medicine.

Source: H219-A/21

Status: 2011; 2016 Reaffirmed; 2021 Reaffirmed

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Residency Training in Canada – Equality Between COCA-Accredited and LCME-Accredited Medical School Graduates Seeking

Policy Statement

The American Osteopathic Association (AOA) supports efforts to restore the equal eligibility standards and criteria for Canadian residency training positions that existed prior to June 2014 for both United States Liaison Committee on Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA) accredited medical schools.

The AOA encourages relevant Canadian authorities to restore the post-graduate medical education eligibility rules in place prior to June 2014 and advocates Canadian authorities restore equal LCME and COCA eligibility that existed prior to June 2014.

Source: H220-A/21

Status: 2016; 2021 Reaffirmed

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Ambulatory-Based Primary Care Residency Programs

Policy Statement

The American Osteopathic Association supports and advocates for development and implementation of ambulatory-based primary care residency programs; encourages the US Congress and state legislatures to strengthen its graduate medical education reimbursement policies to, at least, equivalently fund ambulatory-based primary care residency programs; and will lobby Congress and state legislatures to support legislation funding demonstration models of ambulatory-based primary care residency programs.

Source: H201-A/22

Status: 2012; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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Joining Forces Initiative

Policy Statement

The American Osteopathic Association (AOA) will continue to encourage the American Association of Colleges of Osteopathic Medicine (AACOM) to partner with the Association of American Medical Colleges (AAMC) to promote and develop curriculum that will help osteopathic and allopathic medical students prepare to care for the unique issues returning veterans and their families face; will encourage practicing osteopathic physicians to care for veterans and their families and to accept Tri-Care; will help develop continuing medical education that will help prepare the existing osteopathic work force to comprehend and be prepared to manage the unique issues faced by the veteran population and military families; will encourage the National Board of Osteopathic Medical Examiners (NBOME) to incorporate military service-related conditions in the development of case-based evaluation items for testing; and will support efforts to support veterans and military families by partnering with organizations such as Joining Forces and other organizations that help military members and their families.

Source: H202-A/22

Status: 2007; 2012 Reaffirmed; 2022 Reaffirmed

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Education for Performance of Disability Assessment

Policy Statement

The American Osteopathic Association supports education, training, and involvement of osteopathic physicians in the process of impairment ratings as they may be used to establish disability determinations.

Source: H203-A/22

Status: 2002; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed; 2022 Reaffirmed as Amended

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Supervision for Osteopathic Manipulative Treatment

Policy Statement

The American Osteopathic Association strongly encourages all qualified supervising physicians to foster the appropriate utilization of osteopathic diagnosis and osteopathic manipulative treatment by students, interns and residents assigned to them.

Source: H205-A/22

Status: 1997; 2002 Reaffirmed; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed; 2022 Reaffirmed

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Training Reaffirmation of Primary Care Physicians

Policy Statement

The American Osteopathic Association (AOA) reaffirms its commitment to train competent and compassionate primary care physicians through undergraduate medical education, graduate medical education and continuing medical education.

Source: H206-A/22

Status: 1992; 1997 Reaffirmed; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed; 2022 Reaffirmed as Amended

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Longitudinal Approach to Cultural Competency Dialogue on Eliminating Health Care Disparities

Policy Statement

The American Osteopathic Association encourages evidence-based education and dialogue in cultural competency, the social determinants of health, and the physician's role in eliminating health care disparities.

Source: H208-A/22

Status: 2017; 2022 Reaffirmed as Amended

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United States Immigration Executive Order Impact on Medical Education

Policy Statement

The American Osteopathic Association strongly opposes any potential travel bans created against medical students, interns, residents, fellows, and physicians with visas or green cards and will work to support its patients, students, residents, fellows, and physicians affected by such policies.

Source: H209-A/22

Status: 2017; 2022 Reaffirmed

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Importance of Empathy in Osteopathic Medical Education and Practice

Policy Statement

The American Osteopathic Association recognizes the importance of empathy in osteopathic medical education and practice and the relationship between empathy and well-being of physicians-in-training and in-practice.

Source: H210-A/22

Status: 2017; 2022 Reaffirmed as Amended

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Equivalency Policy for Osteopathic Continuous Certification

Policy Statement

The American Osteopathic Association (AOA), through its Bureaus, Committees and Councils, will ensure that Osteopathic Continuous Certification (OCC) is comparable to other maintenance of certification programs so that OCC can be recognized by the federal government, state governments and other regulatory agencies and credentialing bodies as an equivalent of other national certifying bodies' "maintenance" or "continuous" certification programs.

While the AOA supports the use of board certification as a mark of academic achievement, the AOA opposes any efforts to require OCC as a condition for medical licensure, insurance reimbursement, hospital privileges, network participation, malpractice insurance coverage or as a requirement for physician employment.

That the AOA through the Bureau of Osteopathic Specialists (BOS) will review the OCC process so as to make it more manageable and economically feasible.

Source: H211-A/22

Status: 2010; 2015 Reaffirmed as Amended; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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Loan Deferment During Residency

Policy Statement

The American Osteopathic Association (AOA) supports legislation that would allow medical students and resident physicians to defer the repayment of their federal medical school loans interest free until the completion of residency training.

Source: H212-A/22

Status: 2012; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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Osteopathic Licensing

Policy Statement

The American Osteopathic Association reaffirms its position that the only examinations able to fully evaluate the ability and competency of osteopathic physicians for licensure are the examinations developed by the National Board of Osteopathic Medical Examiners, Inc.

Source: H213-A/22

Status: 1982; 1987 Reaffirmed as Amended; 1987 Reaffirmed as Amended, 1992 Reaffirmed; 1997 Reaffirmed; 2002 Reaffirmed; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed; 2022 Reaffirmed

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Osteopathically Recognized Graduate Medical Education Programs

Policy Statement

The American Osteopathic Association opposes any federal or state laws or regulations that would prevent the development of additional osteopathically recognized graduate medical education programs or training positions and the AOA will continue to take all measures possible to prevent the termination of distinctive osteopathic training programs.

Source: H214-A/22

Status: 1997; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended; 2022 Reaffirmed as Amended

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Certifying Residents for Board Eligibility

Policy Statement

The American Osteopathic Association (AOA) advocates within its resources on behalf of internal medicine residents and fellows, and program directors at the federal, state, and local level so that they be able to sit for internal medicine board certification of their choosing; and that the AOA advocate for all AOA board certified program directors to be able to certify that their residents are eligible for the relevant AOA and/or ABMS board certification of their choosing.

Source: H219-A/22

Status: 2017; 2022 Reaffirmed as Amended

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Physician Designation, Truth in Advertising and Residency/Fellowship Training Non-Physician Post Graduate Medical Training

Policy Statement

The American Osteopathic Association (AOA) work with the American Medical Association (AMA) and other relevant stakeholders to assure that funds to support the expansion of post-graduate clinical training for non-physicians do not divert funding from physician (Graduate Medical Education) GME; and, that the AOA oppose non-physician healthcare providers from holding a seat on medical boards that provide oversight of physician undergraduate medical education, graduate medical education, certification or licensure, and advocate that a non-physician seat on these boards be held by non-medical public professionals.

Source: H220-A/22

Status: 2022 Reaffirmed as Amended

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Develop and Implement Curriculum on the Care of People with Developmental Disabilities

Policy Statement

The American Osteopathic Association (AOA) reaffirms the ideals set in the Americans with Disabilities Act (ADA); and that the AOA encourage osteopathic medical schools to develop and implement curricula on the care of people with developmental disabilities.

Source: H200-A/23

Status: 2018; 2023 Adopted

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DO Degree Designation

Policy Statement

The American Osteopathic Association (AOA) enthusiastically embraces the heritage and philosophy of Dr. Andrew Taylor Still by reaffirming that DO's be the recognized degree designation for all graduates of AOA Commission on Osteopathic College Accreditation (COCA) accredited colleges of osteopathic medicine.

Source: H201-A/23

Status: 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Adopted as Amended

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Enhancing Preceptor Knowledge of Osteopathic Manipulative Treatment (OMT) - Promoting use of

Policy Statement

The American Osteopathic Association (AOA) encourages osteopathic medical schools to provide hands-on Osteopathic Manipulative Treatment (OMT) training and practice sessions to preceptors in order to increase their knowledge of osteopathic manipulative treatment.

Source: H202-A/23

Status: 2013; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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Osteopathic Postdoctoral Training in all Specialty Areas

Policy Statement

The American Osteopathic Association (AOA) representing a comprehensive profession of medicine and surgery affirms its commitment to quality osteopathic postdoctoral training and supports the development and continuation of osteopathically recognized programs in all specialty areas.

Source: H203-A/23

Status: 1993; 1998 Reaffirmed as Amended, 2003 Reaffirmed as Amended; 2008 Reaffirmed; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted as Amended

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Sex and Gender Based Medicine

Policy Statement

The American Osteopathic Association (AOA) supports including relevant pathophysiology and evidence-based medicine regarding sex and gender based healthcare in medical education programs and curricula across the continuum.

Source: H205-A/23

Status: 2018; 2023 Adopted as Amended

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Sale of Health-Related Products and Devices

Policy Statement

The American Osteopathic Association (AOA) believes it is appropriate for physicians to derive reasonable monetary gain from the sale of health-related products or devices that are both supported by rigorous scientific testing or authoritative scientific data. The sale of these products and devices to patients must be deemed to be medically necessary or be able to provide a significant health benefit provided that such action is permitted by the state licensing board(s) of the state(s) in which the physician practices; and inappropriate and unethical for physicians to use their physician/patient relationship to attempt to involve any patient in a program for the patient to distribute health related products or devices in which distribution results in a profit for the physician.

Source: H206-A/23

Status: 1999; 2004 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Adopted as Amended

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Acupuncture

Policy Statement

The American Osteopathic Association (AOA) recognizes that acupuncture may be a part of the armamentarium of qualified and licensed physicians.

Source: H207-A/23

Status: 1978; 1983 Reaffirmed; 1988 Reaffirmed as Amended, 1993; 1998 Reaffirmed, 2003; 2008 Reaffirmed; 2013; 2018 Reaffirmed; 2023 Adopted

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Osteopathic Continuous Certification

Policy Statement

The American Osteopathic Association (AOA) encourages input from osteopathic physicians on maintenance of licensure, maintenance of certification and osteopathic continuous certification rules.

Source: H209-A/23

Status: 2013; 2018 Reaffirmed; 2023 Adopted

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Truth in Advertising – Physician Degrees

Policy Statement

The American Osteopathic Association (AOA) will remain vigilant for any false or erroneous information that might undermine the integrity of the profession or osteopathic medicine in the U.S. and will work with the Federation of State Medical Boards (FSMB) and its constituent boards to inform them of attempts to misrepresent the practice of osteopathic medicine in the U.S. or to misrepresent the education leading to the degree Doctor of Osteopathy or Doctor of Osteopathic Medicine.

Source: H210-A/23

Status: 1969; 1978 Reaffirmed; 1983 Reaffirmed as Amended, 1988 Reaffirmed; 1993 Reaffirmed; 1998 Reaffirmed as Amended; 2003 Reaffirmed as Amended; 2008 Reaffirmed as Amended; 2013 Reaffirmed; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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Exploring the Impact of Virtual Residency Interviews on Osteopathic Residency Match Rate

Policy Statement

The American Osteopathic Association (AOA) encourages collaboration among relevant stakeholders to analyze the impact of the virtual residency interview process on the osteopathic residency placement rate.

Source: H211-A/23

Status: 2023

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Support for Inclusion of Osteopathic Applicants into competitive Postgraduate Training

Policy Statement

The American Osteopathic Association (AOA) encourage its specialty colleges to enhance career counseling and mentorship programs for DO students interested in pursuing competitive specialties, particularly surgical specialties providing students with the necessary guidance and support throughout their educational journey. The AOA and its specialty colleges call upon all professional organizations to actively engage with DOs, providing opportunities for collaboration, research, professional development, and leadership. The AOA will work closely with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant organizations to educate program directors of accredited programs to accept qualified osteopathic residency applicants.

Source: H214-A/23

Status: 2023

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Mandatory CME Course Requirements

Policy Statement

The American Osteopathic Association (AOA) opposes state and federal attempts to impose any specific Continuing Medical Education (CME) course requirements and will assist affiliate societies in opposing attempts to impose specific CME course requirements.

Source: H200-A/24

Status: 2004; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted as Amended

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Health Care Shortage in Rural America

Policy Statement

The American Osteopathic Association (AOA) encourages the development of teaching centers in rural Federally Qualified Health Centers and other eligible entities and supports the teaching health center graduate medical education grant program, so that residents can train and stay in these areas and practice osteopathic medicine.

Source: H201-A/24

Status: 2014; 2019 Approved as Amended; 2024 Adopted as Amended

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Graduate Medical Education – Increasing Opportunities

Policy Statement

The American Osteopathic Association (AOA) supports the efforts to increase the number of graduate medical education training positions available to United States medical graduates.

Source: H202-A/24

Status: 2014; 2019 Reaffirmed; 2024 Adopted

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Integrity and Mission of COMs UHSC Granting the DO – Maintaining the

Policy Statement

The American Osteopathic Association (AOA) upholds and supports maintaining the integrity and mission of Colleges of Osteopathic Medicine and University Health Science Centers granting the Doctor of Osteopathic Medicine degree.

Source: H204-A/24

Status: 2009; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted

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Psychiatry Curriculum and Staffing

Policy Statement

The American Osteopathic Association (AOA) supports the use of members of the American College of Osteopathic Neurology and Psychiatry (ACONP) and their commitment to serve as a resource for developing Educational Components, core competencies, learning objectives, and educational experiences for osteopathic psychiatry both in undergraduate and graduate medical education.

Source: H205-A/24

Status: 2009; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted as Amended

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Community-Based Teaching Health Centers Residency Support

Policy Statement

The American Osteopathic Association (AOA) supports community-based programs as a model of training for osteopathic primary care residents throughout the United States.

Source: H206-A/24

Status: 2014; 2019 Reaffirmed; 2024 Adopted

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Vaccination Policy for Osteopathic Medical Schools

Policy Statement

The American Osteopathic Association (AOA) recommends and supports that all osteopathic medical schools have an ongoing vaccination policy for students.

Source: H207-A/24

Status: 2009; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted as Amended

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American Osteopathic Association Specialty Board Certification

Policy Statement

The American Osteopathic Association (AOA):

1. Reaffirms its commitment to the inclusion of osteopathic principles and practice in every osteopathic board certification examination, regardless of specialty

2. Continues the opportunity for osteopathic certifying boards to develop and administer OMM/OMT practical examinations which are specific and appropriate for their specialty

3. Allows a requirement for specialty-specific content in CME for re-certification-/continuing certification

4. Continues to encourage the Accreditation Council for Graduate Medical Education to include an osteopathic educational component in Osteopathic Recognized programs.

Source: H208-A/24

Status: 2019; 2024 Adopted as Amended

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Education of Students and Faculty on Obtaining Permission Before All Student and Patient Encounters

Policy Statement

The American Osteopathic Association (AOA) encourage all colleges of osteopathic medicine to prepare their educators and graduates to learn and demonstrate aptitude concerning the knowledge and practice of obtaining permission; and, that the AOA promote and encourage both educators and students in the use of obtaining permission in all OMT and/or physical contact patient interactions – whether they be students in educational activities, standardized patients, or others in all educational and clinical activities.

Source: H209-A/24

Status: 2019; 2024 Adopted

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Underage Alcohol Use

Policy Statement

The American Osteopathic Association (AOA) encourages continuing medical education for healthcare professionals to aid them in educating K through 12 school students about the dangers of alcohol and encourages outreach programs to create awareness of the dangers of alcohol.

Source: H211-A/24

Status: 2009; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted as Amended

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Inhalation of Volatile Substances

Policy Statement

The American Osteopathic Association (AOA) encourages continuing medical education and medical literature to enhance physician awareness of inhalation of volatile substances (huffing) and encourages campaigns to enhance public awareness of this problem.

Source: H212-A/24

Status: 2009; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted as Amended

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Clinical Rotations For International Medical Students and Non-Physician Trainees

Policy Statement

The American Osteopathic Association (AOA) supports adequate quality rotations for medical students as they pursue clinical education; and, in concert with other healthcare organizations, federal, state, and local governments, will oppose policies that provide an unfair advantage to internationally-educated medical students and non-physician trainees.

Source: H213-A/24

Status: 2009; 2014 Reaffirmed; 2019 Approved as Amended; 2024 Adopted as Amended

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American Osteopathic Board of Pediatrics (AOBP)

Policy Statement

The American Osteopathic Association (AOA) officially recognizes the American College of Osteopathic Pediatricians (ACOP) as the official medical home and educational organization for all osteopathically trained pediatric residents and trainees.

The AOA recognizes the American Osteopathic Board of Pediatrics (AOBP) as the primary certifying organization for all osteopathically trained pediatric residents, with the exception of those pediatric residents wishing to extend training to a pediatric subspecialty for which the AOBP does not currently have a certifying examination.

The AOA will support the ACOP in ongoing efforts with the Association of Pediatric Program Directors (APPD) to encourage all DO pediatric residents to continue membership in the ACOP by establishing institutional memberships similar to those currently offered by the AAP to residency programs to ensure the smooth transition from student-member to resident-member status.

The AOA will continue to support and engage with the ACGME and ABP to encourage the acceptance and equivalence of the AOBP Pediatric certifying exam for DO-trained pediatric residents who wish to continue training in an ACGME-accredited pediatric subspecialty fellowship. While the AOBP continues to further expand its subspecialty offerings.

Source: H214-A/24

Status: 2024 Adopted as Amended

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Assessing the Impact of Alternative Application Processes on Osteopathic Student Residency Placement Rates

Policy Statement

The American Osteopathic Association (AOA) shall collaborate with relevant stakeholders to analyze the impacts of the current residency application processes on DO placement rates.

Source: H215-A/24

Status: 2024 Adopted as Amended

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Support for Increasing Access to Training Opportunities in American Indian and Alaska Native Communities

Policy Statement

The American Osteopathic Association (AOA) encourages policy and communication efforts to advance legislative and regulatory policies and actions that will establish, authorize, fund, and incentivize the creation of graduate medical education opportunities in IHS, Tribal-administered, and urban Indian health organizations and facilities and establish associated partnerships with accredited medical schools and teaching hospitals.

The AOA encourages working with Tribal nations, Tribal organizations, academic medical centers, policy professionals, medical schools, teaching hospitals, coalition builders, and other external stakeholders to advocate to Congress, The White House, the Department of Health and Human Services, and other government entities for the development and establishment of dedicated graduate medical education funding and programs that benefit Tribal communities, increase physician training sites, and reduce physician shortages, particularly among underserved populations.

Source: H217-A/24

Status: 2024 Adopted as Amended

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Support for the Creation of Specialty and Sub-Specialty Osteopathic Recognition Training Exams

Policy Statement

The American Osteopathic Association (AOA) advocate for the creation of both specialty and subspecialty-focused knowledge-based assessments similar to the CORTEx for programs outside of primary care to meet the Osteopathic Recognition requirement.

Source: H218-A/24

Status: 2024 Adopted as Amended

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Support of the Physical Examination in Education and Practice

Policy Statement

The American Osteopathic Association (AOA) emphasizes the importance of physical examination as an integral part of the evaluation of the patient; and,
The AOA recommend faculty and preceptors in Undergraduate Medical Education (UME) and Graduate Medical Education (GME) emphasize and model the utility of the physical examination to learners.

Source: H219-A/24

Status: 2024 Adopted as Amended

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Resolution on Credential Requirements for Presidents and Leaders of Osteopathic Medical Specialty Colleges

Policy Statement

The American Osteopathic Association (AOA) hereby recommends:

That all candidates seeking leadership within osteopathic medical specialty colleges be physicians holding one or more of the following credentials: Doctor of Osteopathic Medicine (DO), Doctor of Medicine (MD), or Bachelor of Medicine, Bachelor of Surgery (MBBS).

Source: H221-A/24

Status: 2024 Adopted as Amended

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Importance of Accredited Training and Board Certification in Aerospace Medicine for the Growing Commercial Space Industry

Policy Statement

The American Osteopathic Association (AOA) affirms the importance of ACGME and international equivalent-accredited, standardized training and board certification in Aerospace Medicine as the highest standard of comprehensive physician training for human health, performance, and safety in human spaceflight and commercial aviation.

The AOA recommends corporate and government aerospace communities have board-certified Aerospace Medicine (AM) physicians in leadership and operational roles within their integrated Aerospace Medicine (AM) and healthcare management teams.

The AOA encourages current AM specialists to guide and mentor new programs and trainees toward a path of obtaining internationally recognized credentials, including but not limited to Royal College of Physicians (UK), American Board of Preventive Medicine, and American Osteopathic Board of Preventive Medicine board certification in order to maintain the aforementioned standards as the commercial space industry expands.

Source: H222-A/24

Status: 2024 Adopted as Amended

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Certifying Board Services Workgroup Report (Policy H212-A/23 Promotion of AOA Board Certification)

Policy Statement

The 2024 House of Delegates accepts the AOA Certifying Board Services Workgroup Report

AOA Certifying Board Services Workgroup Report

In April 2023, Ira P. Monka, DO, then President-Elect, established the AOA Certifying Board Services Workgroup. The desired outcomes of the workgroup were:

- Establish specific recommendations to enhance initial AOA Board Certification as the premier choice for osteopathic residents and fellows.

- Establish specific recommendations to enhance Osteopathic Continuous Certification process for current diplomates.

Twenty-five individuals were appointed to the Workgroup, under the leadership of Co-Chairs Stephen M. Scheinthal, DO and Bruce A. Wolf, DO. The Workgroup membership included leaders who serve as Designated Institutional Officers (DIO), Deans, Program Directors, and Directors Osteopathic Education as well as individuals with extensive experience on the Bureau of Osteopathic Specialists, Specialty Certifying Board Chairs, and specialty colleges. In addition, there were specialty/state affiliate executive directors and new diplomates, residents, fellows, and students.

The Workgroup met monthly from May to September. The first meetings focused on conducting a SWOT analysis, TOWS analysis, problem identification, and solution generation. Following its August meeting, the Workgroup drafted 38 recommendations. The draft recommendations were distributed in a feedback survey to Workgroup members, Bureau of Osteopathic Education members, Bureau of Osteopathic Specialists members, Bureau of Emerging Leaders members, specialty certifying board members, and state and specialty affiliate executive directors. Seventy-five individuals responded. In addition, Certifying Board Services staff also provided their input utilizing their knowledge about the operationality of the recommendations. Utilizing the feedback received from stakeholders, the recommendations were revised and consolidated to 17 recommendations. Workgroup members then finalized and prioritized the recommendations at their September meeting for submission to the BOT.

The BOT approved the 17 recommendations at their October meeting:

1. Work with Marketing staff and AOA specialty certifying board staff to develop engaging, persuasive, and specialty-specific content for DIOs, program directors, coordinators, AOA board-certified core faculty, and residents.
   - Utilize analytics to provide more information (i.e., offer webinars, send printed materials) to individuals who open and click links in emails.
   - Provide specialty colleges with copies of these emails to help disseminate the message and be aware when the messaging will be arriving.

- Consider sending emails to residents tailored to their PGY.

2. Simplify/Refresh the AOA Board Certification website, including each individual specialty certifying board's sites, to improve dissemination of specialty-specific information among diplomates, students/COMs, residents, and program directors in order to provide details about board exam processes, roadmaps, and essential resources.
    - For students and residents - a specialty-specific roadmap to major conferences and leadership opportunities that will help shape their career path and lead them to AOA Board Certification.
    - For diplomates – include timeline about the recertification process.
    - For GME leaders - Provide relevant information on exam quality, acceptance, and ACGME requirements, illustrating that selecting AOA over ABMS board certification will ensure that residents are not left out from future opportunities.

3. Engage with all program directors to ensure they know about AOA Board Certification. When new programs are accredited or there is a program director change, contact them to orient them to AOA Board Certification.

4. Continue to stress that it is an ACGME requirement that residents are educated on their board certification options.
    - Collect data on whether residents are receiving information on what boards they are eligible for from their programs. Utilize this data to inform conversations with the ACGME Board and Review Committees.
    - Create PowerPoint slides for teaching purposes at residency programs (information to be given by program coordinators, directors, chief residents).

5. Have a dedicated board certification marketing staff member (similar to the dedicated membership marketing staff) that works closely with AOA specialty certifying board staff to develop engaging, persuasive, and specialty-specific content for various marketing materials such as emails, social media posts, DO articles, and more.

6. Increase the formal AOA Board Certification presentations at national medical education meetings, program director association meetings, student and resident conferences, and osteopathic affiliate conferences, utilizing AOA board certified physicians who will already be attending these conferences to control cost.

7. Refresh AOA Physician Portal to become a one-stop page showing diplomate's OCC status (including action directives) and send out emails with more frequent and personalized information about how to access OCC process.

8. Strengthen relationships with our osteopathic specialty colleges by having at least annual meetings with specialty college and specialty board leadership and no less than semiannual contact between AOA board staff and specialty college staff.

9. Connect with osteopathic stakeholder organizations, specialty colleges, state societies, COM Deans, SOMA and COSGP to begin talking about AOA Board Certification, providing slides and talking points to share at their meetings with students, residents, and medical educators.

10. Continue to support innovations regarding pricing, exam timing, and content to meet the needs of residents, candidates, and diplomates. Partner with specialty colleges and osteopathic foundations for initial certification grants.

11. Provide opportunities for AOA specialty certifying boards to share best practices and their innovative models for longitudinal assessment and quality improvement, striving to be more meaningful and relevant to diplomates.

12. Investigate providing specialty colleges with access to see their member's general certification information (i.e., certification expiration; OCC status) to help answer their members' questions.

13. Engage with state societies specialty boards, and specialty colleges.

14. Increase awareness of AOA board certification with students throughout their medical school journey by including information on board certification in AOA student communications and COM visits.

15. Grow the subject matter expert/item writer pools for each specialty by conducting a needs assessment and organize an item writer recruitment campaign, including highlights of the incentives for AOA certification volunteers (50% off AOA membership, earning CME, exam/longitudinal assessment waivers).

16. Standardize the AOA certifying board member nomination process to reach diplomates who may not be aware of leadership opportunities available and expand our volunteer pool to introduce fresh perspectives that can enrich the certifying board.

17. After passing the initial certification exam, send any information about how new diplomates, maintain OCC, can track their CME and what the AOA certifying board and AOA membership can do for them.

At its Midyear Meeting, the BOT approved the use of $361,000 from reserves for the following items: Director of Certification Marketing FTE, Website enhancements, IT development costs to enhance OCC dashboard, and resident/recent graduate survey.

Source: H223-A/24

Status: 2023; 2024 Adopted as Amended

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SPECIAL MEETING OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
PROFESSIONAL AFFAIRS - RESOLUTION ROSTER
As of September 13, 2020

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:

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

Res. No.	Resolution Title	Submitted By	Reference Committee
H300	Intractable and/or Chronic Pain (Not Associated with End of Life Care) (H327-A/15)	BSGA	Professional
H301	Retail-Based Health Clinics and Urgent Care Centers (H303-A/15)	BSAPH	Professional
H302	Protecting American Students from Profit-Driven Foreign Medical Schools (H304-A/15)	BFHP	Professional
H303	Remove FDA Ban on Anonymous Sperm Donation from Men Who Have Sex with Men (H305-A/15)	BFHP / BSAPH	Professional
H304	Improving Competitive Edge for Membership in the AOA (H308-A/15)	BOM	Professional
H305	Tax Credit for Precepting (H312-A/15)	BSGA	Professional
H306	Site Neutral Reimbursement (H396-A/15)	BFHP	Professional
H307	Supporting the Use of OMM in the VA (H311-A/15)	BHFP	Professional
H308	Practice Rights of Osteopathic Physicians (H313-A/15)	BSGA	Professional
H309	Retail Medical Clinics in Facilities Selling Tobacco, Nicotine or Vaping Products (H314-A/15)	BSAPH	Professional
H310	Osteopath and Osteopathy - Use of the Term (H315-A/15)	BIOM	Professional
H311	Patient Access in Rural Areas (H317-A/15)	BSGA	Professional
H312	Physician Office Laboratories (H318-A/15)	BFHP	Professional
H313	Postgraduate Compensation (H319A/15)	BOE	Professional
H314	Second Opinion, Surgical Cases (H320-A/15)	BSA	Professional
H315	Uniformed Services: Endorsement of Physicians Serving in the Uniformed Services (H322-A/15)	BFHP	Professional
H316	Emergency Medical Services for Children, Support of (H323-A/15)	BFHP	Professional
H317	Physician Incentives to Underserved Areas (H324-A/15)	BSGA	Professional
H318	Vaccines Shortages (H326-A/15)	BFHP	Professional
H319	Medicare Balance Billing (H329-A/15)	BFHP	Professional

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PROFESSIONAL AFFAIRS - RESOLUTION ROSTER
As of September 13, 2020

Res. No.	Resolution Title	Submitted By	Reference Committee
H320	Electronic Prescribing of Controlled Substances (H332-A/15)	BSA	Professional
H321	Professional Organization -- Physicians Choosing to Which They Belong (H334-A/15)	BOM	Professional
H322	Prescription Drug Diversion and Abuse – Education, Research, and Advocacy (H335-A/15)	BSGA	Professional
H323	Buprenorphine Maintenance Treatment Insurance Coverage (H336-A/15)	BSA	Professional
H324	Violence Against Healthcare Staff (H337-A/15)	BSGA	Professional
H325	Low Back Pain Clinical Practice Guidelines, Revision of (H338-A/15)	BOCER	Professional
H326	Addressing the Effects of Climate on National Health	SOMA	Professional
H327	Adverse Childhood Experiences Screening	SOMA	Professional
H328	Inclusion of Patient Education on Organ Donation as a Component of a Primary Care Visit	SOMA	Professional
H329	Inequalities in Medicaid Funding Affecting U.S. Territories	SOMA	Professional
H330	Improving Insulin Affordability	SOMA	Professional
H331	Medication for Opioid Use Disorder Insurance Coverage	AOAAM	Professional
H332	Recruitment and Retention of Native Americans in Medicine	SOMA	Professional
H333	WITHDRAWN	SOMA	Professional
H334	Sustainability at AOA Events	MOA	Professional
H335	H357-A/19 Nutrition and Leading By Example	OPSC	Professional
H336	REFERRED RESOLUTION: H324-A/14 Use of the Term "Physician" "Doctor" and "Provider"	BSGA	Professional
H337	CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016	IOMA	Professional

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
PROFESSIONAL AFFAIRS (300 SERIES)

House of Delegates' Reference Committee Description:
Committee on Professional Affairs (300 series)
This reference committee reviews and considers matters relating to osteopathic health care facilities, advocacy, legislation, membership and conventions.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-300	Medication For Opioid Use Disorder (MOUD) Availability for Incarcerated Individuals and/or Individuals Under Correctional Control	AOAAM	Professional Affairs	ADOPTED as AMENDED
H-301	Availability of Modalities of Prescribing	OOA	Professional Affairs	ADOPTED as AMENDED
H-302	Improving Insulin Affordability	SOMA	Professional Affairs	ADOPTED as AMENDED
H-303	Direct Acting Therapy for Hepatitis C Limitations	OOA	Professional Affairs	ADOPTED as AMENDED
H-304	Extension of the Shelf-Life Extension Program (SLEP) by the FDA	OOA	Professional Affairs	ADOPTED as AMENDED
H-305	Increasing Voter Access ~~Amongst~~ FOR Hospitalized Patients	SOMA	Professional Affairs	ADOPTED as AMENDED
H-306	Support of Continued Funding for ~~Americorps National Service Programs~~ CORPORATION FOR NATIONAL AND COMMUNITY SERVICE (CNCS)	SOMA	Professional Affairs	ADOPTED as AMENDED
H-307	Appropriate PPE Usage PROVISIONS	BEL	Professional Affairs	ADOPTED as AMENDED
H-308	Referred Sunset Res. No. H300-A/20; H327-A/15 intractable and / or Chronic Pain (Not Associated with End of Life Care)	CSHA	Professional Affairs	ADOPTED as AMENDED

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
PROFESSIONAL AFFAIRS (300 SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-309	Conflicts of Interest	MAOP	Professional Affairs	ADOPTED as AMENDED
H-310	Resolution Withdrawn			
H-311	Revision of the Invocation to Support Inclusive and Interfaith Language	MOA	Professional Affairs	ADOPTED as AMENDED
H-312	Support of State Societies (SR-Source: H207-A/16)	BOM	Professional Affairs	ADOPTED *for Sunset*
H-313	Center of Excellence for Stroke (SR-Source: H306-A/16)	BFHP	Professional Affairs	ADOPTED as AMENDED
H-314	Voting Day – AOA Supports Voting Day Policy (SR-Source: H307-A/16)	BFHP	Professional Affairs	ADOPTED
H-315	Patient Care at Extended Long Term Care Facilities (SR-Source: H308-A/16)	BFHP	Professional Affairs	ADOPTED
H-316	Osteopathic Term Protection (SR-Source: H310-A/16)	CSHA	Professional Affairs	ADOPTED
H-317	Cyberbullying through Social Media (SR-Source: H316-A/16)	BORPH	Professional Affairs	ADOPTED
H-318	Firearms – Commission of A Crime While Using a Firearm (SR-Source: H318-A/16)	CSHA/BFHP	Professional Affairs	ADOPTED
H-319	Good Samaritan Acts (Hold Harmless Agreement) Performed on Commercial Aircraft (SR-Source: H319-A/16)	CSHA/BFHP	Professional Affairs	ADOPTED
H-320	Medicaid Pharmaceutical Benefits (SR-Source: H320-A/16)	CSHA	Professional Affairs	ADOPTED as AMENDED
H-321	MedicaL~~tion~~ Shortages (SR-Source: H330-A/16)	BFHP	Professional Affairs	ADOPTED as AMENDED
H-322	Health Insurance Availability to Osteopathic Medical Students (SR-Source: H337-A/16)	BFHP	Professional Affairs	ADOPTED
H-323	Behavioral Health Services – Funding and Access ~~Patients in Emergency Departments Topic~~ (SR-Source: H338-A/16)	BFHP	Professional Affairs	ADOPTED as AMENDED
H-324	Physician Gag Rules – Opposition to (SR-Source: H340-A/16)	BFHP	Professional Affairs	ADOPTED

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
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PROFESSIONAL AFFAIRS (300 SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-325	Congressional Budget Office Fiscal Scoring (SR-Source: H343-A/16)	BFHP	Professional Affairs	ADOPTED as AMENDED
H-326	Pain Related Education Requirements (SR-Source: H344-A/16)	CSHA	Professional Affairs	ADOPTED as AMENDED
H-327	Non-Physician Health Care Clinician (SR-Source: H346-A/16)	BFHP	Professional Affairs	ADOPTED
H-328	Eugenic Selection with Preimplantation Genetic Diagnosis (SR-Source: H349-A/16)	BFHP	Professional Affairs	REFERRED
H-329	Tricare Health Insurance for our Military (SR-Source: H350-A/16)	BFHP	Professional Affairs	ADOPTED
H-330	Osteopathic Manipulative Treatment (OMT) in the CDC Chronic Pain Management Guidelines – Inclusion of (SR-Source: H351-A/16)	BORPH	Professional Affairs	ADOPTED as AMENDED
H-331	~~Baby Friendly~~ SUPPORT OF BREASTFEEDING ~~Hospital Initiative (BFHI)~~ (SR-Source: H403-A/16)	BORPH	Professional Affairs	ADOPTED as AMENDED
H-332	Organ And Tissue Donation and Transplantation Initiatives – Commitment to (SR-Source: H411-A/16)	BORPH	Professional Affairs	ADOPTED
H-333	Vaccine Supply and Distribution (SR-Source: H416-A/16)	BORPH	Professional Affairs	ADOPTED
H-334	Health Literacy (SR-Source: H426-A/16)	BORPH	Professional Affairs	ADOPTED
H-335	Onsite Lab Work No. 1 (SR-Source: H600-A/16)	CERA	Professional Affairs	ADOPTED
H-336	Managed Care Referrals (SR-Source: H602-A/16)	CERA	Professional Affairs	ADOPTED
H-337	Medicare Physician Payment for Osteopathic Manipulative Treatment (SR-Source: H621-A/16)	CERA	Professional Affairs	ADOPTED
H-338	Drug Plan Coverage Denials (SR-Source: H628-A/16)	CERA	Professional Affairs	ADOPTED

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
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PROFESSIONAL AFFAIRS (300 SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-339	Payor Adherence to Current Procedural Terminology (CPT) And International Classification of Diseases (ICD) Coding Definitions (SR-Source: H630-A/16)	CERA	Professional Affairs	ADOPTED
H-340	Interference – Lawful Off-Label Treatment of Patients (SR-Source: H634-A/16)	BFHP/CSHA	Professional Affairs	ADOPTED
H-341	Appropriate Payment Mechanisms for Physician-Led Team-Based Health Care (SR-Source: H636-A/16)	CERA/CSHA	Professional Affairs	ADOPTED as AMENDED
H-342	Human Immunodeficiency Virus (HIV) (SR-Source: H408-A/16)	BORPH	Professional Affairs	ADOPTED as AMENDED
H-343	Improving Access to Physician-Led Care	BOT	Professional Affairs	ADOPTED
H-344	Reforming the Health IT Landscape to Improve the Patient and Clinician Experience	BOT	Professional Affairs	ADOPTED

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102nd ANNUAL AOA HOUSE OF DELEGATES
JULY 17, 2022, MEETING
RESOLUTION ROSTER (300 SERIES)

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTIONS:

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

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-300	Defining New Physicians in Practice (SR - Source: H349-A/17)	BEL	Professional Affairs	Adopted
H-301	State Licensure of Managed Care Organizations (MCO) Medical Directors (SR-Source: H302-A/17)	BFHP	Professional Affairs	Adopted
H-302	Administrative Rule-Making Process (SR- Source: H304-A/17)	BFHP	Professional Affairs	Adopted
H-303	Advance Directives (SR- Source: H305-A/17)	BFHP	Professional Affairs	Adopted
H-304	Interstate Opioid Database (SR- Source: H331-A/17)	BORPH	Professional Affairs	Adopted as Amended
H-305	Improve Life-Saving Access to Epinephrine (SR- Source: H333-A/17)	BORPH	Professional Affairs	Adopted as Amended
H-306	Family And Medical Leave Act (FMLA) Documentation (SR- Source: H307-A/17)	BFHP	Professional Affairs	Disapproved (Sunset)
H-307	Prescription Drugs (SR - Source: H308-A/17)	BFHP	Professional Affairs	Adopted
H-308	Federally Funded Health Clinics (SR - Source: H309-A/17)	BFHP	Professional Affairs	Adopted as Amended
H-309	Disparities Between Rural and Urban Practices (SR - Source: H311-A/17)	BFHP	Professional Affairs	Adopted
H-310	Preservation of Antibiotics for Medical Treatment (SR - Source: H312-A/17)	BFHP	Professional Affairs	Adopted
H-311	Guidelines for Nutritional and Dietary Supplements (SR - Source: H315-A/17)	BFHP	Professional Affairs	Adopted
H-312	Sexual Harassment (SR- Source: H316-A/17)	CSHA	Professional Affairs	Adopted as Amended
H-313	Due Process in Agency Determinations (SR- Source: H317-A/17)	BFHP	Professional Affairs	Adopted as Amended
H-314	Ethical And Sociological Considerations for Medical Care (SR - Source: H318-A/17)	BFHP	Professional Affairs	Adopted
H-315	Regulation of Health Care (SR- Source: H319-A/17)	CSHA	Professional Affairs	Adopted as Amended

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102nd ANNUAL AOA HOUSE OF DELEGATES
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RESOLUTION ROSTER (300 SERIES)

H-316	Occupational Safety and Health Administration (OSHA) Regulations (SR - Source: H320-A/17)	BFHP	Professional Affairs	Adopted
H-317	Patient Safety (SR - Source: H321-A/17)	BFHP	Professional Affairs	Adopted as Amended
H-318	Promotion of School Based Health Education (SR - Source: H325-A/17)	CSHA	Professional Affairs	Adopted as Amended
H-319	Recoupment Laws (SR - Source: H326-A/17)	BFHP	Professional Affairs	Adopted
H-320	Right to Practice and Payment for Osteopathic Manipulative Treatment (SR - Source: H329-A/17)	CSHA	Professional Affairs	Adopted
H-321	Equity in Medicare & Medicaid Payments (SR - Source: H339-A/17)	CSHA	Professional Affairs	Adopted as Amended
H-322	Naloxone (SR - Source: H340-A/17)	CSHA	Professional Affairs	Adopted as Amended
H-323	Shared Principles of Primary Care (SR - Source: H342-A/17)	BFHP	Professional Affairs	Adopted
H-324	Eugenic Selection with Preimplantation Genetic Diagnosis (SR -Source: H349-A/16)	BFHP	Professional Affairs	Adopted as Amended
H-325	Interference Laws - Amendment to American Osteopathic Association Policy H358-A/19	IOMA	Professional Affairs	Adopted as Amended

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103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (300 SERIES) w/ACTION
As of 07-24-23

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTIONS:

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

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-300	Adolescents' Bill of Rights (SR-Source:H301-A/18)	BFHP	Professional Affairs	Adopted
H-301	Airline Medical Kits (SR–Source:H302-A/18)	BFHP	Professional Affairs	Referred to AOCOPM
H-302	Direct to Consumer Advertising in Drugs (SR–Source:H353-A/18)	BFHP	Professional Affairs	Adopted
H-303	Discrimination Against Osteopathic Physicians (SR–Source:H304-A/18)	BFHP	Professional Affairs	Adopted
H-304	Durable Medical Equipment Claims Processing (SR–Source:H303-A/18)	BFHP	Professional Affairs	Adopted as Amended
H-305	Equality in the Military – Transgender (SR–Source:H354-A/18)	BFHP	Professional Affairs	Adopted as Amended
H-306	Federal Student Loan Program (SR–Source:H355-A/18)	BFHP	Professional Affairs	Adopted as Amended
H-307	Government Funding for COCA and LCME Accredited Medical Schools and Students Attending such Institutions (SR–Source:H310-A/18)	BFHP	Professional Affairs	Adopted as Amended
H-308	Health Care that Works for all Americans (SR–Source:H313-A/18)	BFHP	Professional Affairs	Adopted as Amended
H-309	Medicare Limiting Charge / RBRVS System (SR–Source:H325-A/18)	BFHP	Professional Affairs	Adopted
H-310	Medicare User Fees (SR–Source:H324-A/18)	BFHP	Professional Affairs	Adopted
H-311	Medicare (SR–Source:H322-A/18)	BFHP	Professional Affairs	Adopted as Amended
H-312	Physicians In Health Professional Shortage Areas – Model Funding to Increase (SR–Source:H311-A/18)	BFHP	Professional Affairs	Adopted
H-313	Primary Care Physicians Programs in Health Professional Shortage Areas (HPSAS) – Funding to Increase (SR–Source:H307-A/18)	BFHP	Professional Affairs	Adopted as Amended
H-314	Rural Healthcare Payment Equity (SR–Source:H334-A/18)	BFHP	Professional Affairs	Adopted

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Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-315	Uninsured – Access Health Care (SR–Source:H338-A/18)	BFHP	Professional Affairs	Adopted
H-316	Terminology – Volunteer Osteopathic Medical Health Care Delivery (SR-Source:H349-A/18)	BFHP	Professional Affairs	Adopted
H-317	Osteopathic Medicine Definition (SR-Source:H300-A/18)	BOE	Professional Affairs	Adopted
H-318	Health Care Providers Right of Conscience (SR-Source:H314-A/18)	BOM	Professional Affairs	Adopted as Amended
H-319	Physician Health Assistance (SR-Source:H331-A/18)	BOM	Professional Affairs	Adopted
H-320	Social Media Guidelines – ~~IMPLEMENTATION~~ (SR-Source:H348-A/18)	BOM	Professional Affairs	Adopted as Amended
H-321	Alcohol and Tobacco – Advertising Ban on (SR-Source:H308-A/18)	BORPH	Professional Affairs	Adopted as Amended
H-322	Obesity – Health Plans Should Include Benefits for Treatment of (SR-Source:H327-A/18)	BORPH	Professional Affairs	Adopted as Amended
H-323	Osteopathic Manipulative Treatment (OMT) for Low Back Pain (Response to Res. No. H-334-A/2017) (SR-Source:H358-A/18)	BORPH	Professional Affairs	Adopted
H-324	Physician Fees and Charges (SR-Source:H330-A/18)	CERA	Professional Affairs	Adopted as Amended
H-325	Physician Payment for Electronic Advice, Counseling, and Treatment Plans (SR-Source:H343-A/18)	CERA	Professional Affairs	Adopted as Amended
H-326	Electronic Health Records – ~~Increasing~~ Drug **INTERACTION WARNINGS** (SR-Source:H350-A/18)	CERA	Professional Affairs	Adopted as Amended
H-327	Evaluation And Management Documentation Guidelines (SR-Source:H312-A/18)	CERA	Professional Affairs	Adopted
H-328	Healthcare Practice- Patient-Physician Relationship and (SR-Source:H319-A/18)	CERA	Professional Affairs	Adopted as Amended
H-329	Mandatory Assignment (SR-Source:H320-A/18)	CERA	Professional Affairs	Adopted
H-330	Medical Records- Policy/Guidelines for the Maintenance, Retention, and Release of (SR–Source:H321-A/18)	CERA	Professional Affairs	Adopted as Amended

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103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (300 SERIES) w/ACTION
As of 07-24-23

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-331	Osteopathic Manipulative Treatment and Evaluation and Management on the Same Day of Service- Payment for (SR-Source:H328-A/18)	CERA	Professional Affairs	Adopted as Amended
H-332	Patient Confidentiality (SR-Source:H329-A/18)	CERA	Professional Affairs	Adopted
H-333	Pre-Filled Medical Necessity Form (SR-Source:H344-A/18)	CERA	Professional Affairs	Adopted
H-334	Referrals and Consults- Non-Physician Disclosures (SR-Source:H345-A/18)	CERA	Professional Affairs	Adopted
H-335	Tobacco Use (SR-Source:H335-A/18)	CERA	Professional Affairs	Adopted
H-336	Uniform Billing (SR-Source:H336-A/18)	CERA	Professional Affairs	Adopted
H-337	Expert Witness & Peer Review (SR-Source:H341-A/18)	CSHA	Professional Affairs	Adopted as Amended
H-338	Payors – Osteopathic Discrimination by (SR-Source:H318-A/18)	CSHA	Professional Affairs	Adopted
H-339	Special Licensing Pathways for Physicians – Opposition to (SR-Source:H363-A/18)	CSHA	Professional Affairs	Adopted as Amended
H-340	Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) (SR–Source:H347-A/18)	CSHA	Professional Affairs	Adopted as Amended
H-341	Timely Posting of Meeting Agendas/Materials and Approval of Meeting Minutes (SR-Source:H351-A/18)	CAGOS	Professional Affairs	Adopted
H-342	Sunset Resolutions (SR–Source:H364-A/18)	CAGOS	Professional Affairs	Adopted as Amended
H-343	Workplace Violence Against Healthcare Providers	MAOP	Professional Affairs	Adopted as Amended
H-344	Withdrawn		Professional Affairs	Withdrawn
H-345	AOA Support for the Fair Access in Residency (Fair) Act, H.R. 751	VOMA	Professional Affairs	Adopted as Amended
H-346	Reinstatement of Annual Board Certification Fee	BOT	Professional Affairs	Adopted as Amended

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103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (300 SERIES) w/ACTION
As of 07-24-23

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-347	Advocate Congress to close the Title IV Loophole that has been used to enable funds to cover the cost of attendance at for profit Medical Schools that would otherwise be Ineligible	NYSOMS	Professional Affairs	Adopted as Amended

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (300 SERIES) W/ACTION
As of 07-22-24

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
Committee on Professional Affairs (300 series)
This reference committee reviews and considers matters relating to osteopathic health care facilities, advocacy, legislation, membership and conventions.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-300	Drug Formularies (SR-Source-H308-A/19)	BFHP	Professional Affairs	Adopted as Amended
H-301	Importation of Medications (SR-Source-H313-A/19)	BFHP	Professional Affairs	Adopted
H-302	Maternal Mortality (SR-Source-H335-A/19)	BFHP	Professional Affairs	Adopted
H-303	Extending Medicaid to 12 Months Postpartum (SR-Source-H336-A/19)	BFHP	Professional Affairs	Adopted as Amended
H-304	Hospital Consolidation – Opposition to (SR-Source-H338-A/19)	BFHP	Professional Affairs	Adopted as Amended
H-305	Misaligned Incentives in Medicare Plans (SR-Source-H342-A/19)	BFHP	Professional Affairs	Adopted as Amended
H-306	Opposing Targeted Regulation of Abortion Providers (Trap Laws) (SR-Source-H335-A/19)	BFHP	Professional Affairs	Adopted as Amended
H-307	Physically Active Video Games – (Exergaming Health) Benefits (SR-Source-H316-A/19)	BORPH	Professional Affairs	Adopted as Amended
H-308	Cardiovascular Disease and Women (SR-Source-H319-A/19)	BORPH	Professional Affairs	Adopted as Amended
H-309	Healthy Weight for Families (SR-Source-H320-A/19)	BORPH	Professional Affairs	Adopted as Amended
H-310	End-of-Life Care – Use of Placebos in (SR-Source-H322-A/19)	BORPH	Professional Affairs	Referred to BORPH
H-311	Abuse of Performance Enhancing Substances and Procedures (SR-Source-H327-A/19)	BORPH	Professional Affairs	Adopted as Amended
H-312	Tobacco Use Status – Reporting in the Medical Record (SR-Source-H329-A/19)	BORPH	Professional Affairs	Adopted
H-313	Testosterone Therapy: Long Term Effect on Health (SR-Source-H332-A/19)	BORPH	Professional Affairs	Adopted as Amended

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (300 SERIES) W/ACTION
As of 07-22-24

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-314	Home-Based Care for Frail Elderly (SR-Source-H309-A/19)	BORPH	Professional Affairs	Adopted as Amended
H-315	Health Care Costs in Long Term Services and Support (SR-Source-H310-A/19)	BORPH	Professional Affairs	Adopted as Amended
H-316	Human Cloning (SR-Source-H341-A/19)	BORPH	Professional Affairs	Adopted as Amended
H-317	White Papers – Updating (SR-Source-H343-A/19)	BORPH	Professional Affairs	Adopted
H-318	Direct-to-Consumer Marketing of Health Screening and Testing (SR-Source-H303-A/19)	BORPH	Professional Affairs	Adopted
H-319	Newborn HIV Testing (SR-Source-H304-A/19)	BORPH	Professional Affairs	Adopted
H-320	Influenza Immunization for Health Care Workers and Educators (SR-Source-H306-A/19)	BORPH	Professional Affairs	Adopted
H-321	Flu Pandemic – Osteopathic Treatment of (SR-Source-H302-A19)	BORPH	Professional Affairs	Adopted
H-322	Osteopathic Manipulative Treatment (OMT) of the Cervical Spine (SR-Source-H324-A/19)	BORPH	Professional Affairs	Adopted as Amended
H-323	Compensation Tied to Patient Satisfaction Surveys – Osteopathic Physician (SR-Source-H333-A/19)	CERA	Professional Affairs	Adopted as Amended
H-324	Administrative Fees (SR-Source-H321-A/19)	CERA	Professional Affairs	Adopted
H-325	Availability of Biosimilar Products (SR-Source-H334-A/19	CERA	Professional Affairs	Adopted as Amended
H-326	Medicare – Prescription Assistance for Medicare Patients (SR-Source-H317-A/19)	CERA	Professional Affairs	Adopted as Amended
H-327	State Graduate Medical Education Funding Alternatives (SR-Source-H359-19)	CSHA	Professional Affairs	Adopted as Amended
H-328	Office Based Surgery (SR-Source-H360-A/19)	CSHA	Professional Affairs	Adopted as Amended
H-329	Uniform Pathway of Licensing of Osteopathic Physicians (SR-Source-H361-A/19)	CSHA	Professional Affairs	Adopted

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (300 SERIES) W/ACTION
As of 07-22-24

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-330	Safe Haven Non-Reporting Protection for Physicians-Support for (SR-Source-H362-A/19)	CSHA	Professional Affairs	Adopted as Amended
H-331	Electronic Prescribing (H327-A/14) (SR-Source-H318-A/19)	CSHA	Professional Affairs	Not Adopted
H-332	Right to Privately Contract (H334-A/14) (SR-Source-H325-A/19)	CSHA	Professional Affairs	Sunset
H-333	Any Willing Provider Legislation (SR-Source-H314-A/19)	CSHA	Professional Affairs	Adopted as Amended
H-334	Pharmacy Benefit Managers-Increased Regulation of (SR-Source-H339-A/19)	CSHA	Professional Affairs	Adopted as Amended
H-335	Support for OMT Privileges (SR-Source-H349-A/19)	BOE	Professional Affairs	Referred to BOE
H-336	Diversity In Leadership Positions (SR-Source-H328-A/19)	BOM	Professional Affairs	Adopted
H-337	Due Process for Alleged Impaired Physicians (SR-Source-H307-A/19)	BOM	Professional Affairs	Adopted
H-338	National Practitioner Data Bank-Membership Action (SR-Source-H312-A/19)	BOM	Professional Affairs	Adopted
H-339	Promoting Diversity in AOA Membership and Leadership (SR-Source-H326-A/19)	BOM	Professional Affairs	Adopted as Amended
H-340	Clarification on the Terms "Osteopathy, and "Osteopath" in the United States (Amendment to Policy H316-A/21)	OPSC (California)	Professional Affairs	Adopted as Amended
H-341	Increased awareness of Mental Health Conditions in Nursing Home Residents	SOMA	Professional Affairs	Adopted as Amended
H-342	Airline Medical Kits (SR-Source-H302-A/18)	AOCOPM	Professional Affairs	Adopted as amended
H-343	Whistleblower Policy (SR-Source-H346-A/19)	AOA BOT	Professional Affairs	Adopted as Amended
H-344	Locations of Future Meetings	FOMA (Florida)	Professional Affairs	Not Adopted
H-345	Opioid Crisis, Causes	IOMA (Iowa)	Professional Affairs	Adopted as Amended

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As of 07-22-24

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-346	Supporting the Rights of Residents to Unionize	MOA (Michigan)	Professional Affairs	Adopted as Amended
H-347	Expanding Naloxone and other Opioid Reversal Agent or Antagonist availability and accessibility: Promoting Emergency use in Communities	MOA (Michigan)	Professional Affairs	Adopted as Amended
H-348	GME Equity Annual Report (Policy H345-A/23 – AOA Support for GME Equity)	AOA BOT	Professional Affairs	Adopted
H-349	Removing intrusive Mental Health Questions from Licensure and Credentialing Applications	ACOFP	Professional Affairs	Not Adopted

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Retail-Based Health Clinics and Urgent Care Centers

Policy Statement

The American Osteopathic Association recommends that retail-based health clinics and urgent care centers adhere to the following principles and standards to guide their establishment and operation.

1.Retail-based health clinics and urgent care centers must establish arrangements by which their health care practitioners have direct access to and supervision by physicians at levels that meet or exceed respective state laws.

2.Retail-based health clinics and urgent care centers must encourage patients to establish care with a primary care physician to ensure continuity of care. If a patient's conditions or symptoms are beyond the scope of services provided by the clinic, that patient must immediately be referred to an appropriate physician or emergency facility. Also, retail-based health clinics urgent care centers should be encouraged to use electronic health records as a means of communicating information with the patient's primary physician and facilitating continuity of care.

3.Whether by electronic communication, or some other acceptable means, retail-based health clinics urgent care centers must send detailed information on services provided to the patient's primary care physician in a timely manner to ensure continuity of care.

4.The clinic must have a well-defined and limited scope of clinical services. These services must not exceed the on-site health provider's scope of practice, as determined by state law.

5. Retail-based health clinics and urgent care centers must use standardized medical protocols developed from evidence-based practice guidelines for non-physician practitioners.

6. Retail-based healthcare clinics and urgent care centers must comply with all applicable standards of state and federal regulations expected of physician offices.

7. Retail-based healthcare clinics and urgent care centers must not expand into programs offering patient care for the management of chronic and complex conditions.

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

Source: H301-A/20

Status: 2006; 2011 Reaffirmed as Amended; 2015 Revised; 2020 Reaffirmed as Amended

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Protecting American Students from Profit-Driven Foreign Medical Schools

Policy Statement

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

Source: H302-A/20

Status: 2015; 2020 Reaffirmed

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Tax Credit for Precepting

Policy Statement

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

Source: H305-A/20

Status: 2015; 2020 Reaffirmed as Amended

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Tax Credit for Precepting

Policy Statement

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

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

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

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

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

Source: H306-A/20

Status: 2015; 2020 Reaffirmed as Amended

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Practice Rights of Osteopathic Physicians

Policy Statement

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

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

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

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

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

Source: H308-A/20

Status: 1999; 2004 Reaffirmed as Amended; 2009 Reaffirmed as Amended; 2015 Reaffirmed; 2020 Reaffirmed as Amended

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Retail Medical Clinics in Facilities Selling Tobacco, Nicotine or Vaping Products

Policy Statement

The American Osteopathic Association (AOA) discourages the placement of medical practices and limited-service clinics in retail settings that promote and sell tobacco because it is contrary to the efforts and standards of the health care community at large.

Source: H309-A/20

Status: 2010; 2015 Reaffirmed as Amended; 2020 Reaffirmed as Amended

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Osteopath and Osteopathy - Use of the Term

Policy Statement

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

(1) previously named entities within the osteopathic medical profession;
(2) historical, sentimental, and informal discussions; and
(3) osteopaths with a limited scope of practice.

Source: H310-A/20

Status: 1994; 2000 Reaffirmed; 2005 Reaffirmed as Amended; 2010 Reaffirmed as Amended; 2015 Reaffirmed as Amended; 2020 Reaffirmed

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Physician Office Laboratories

Policy Statement

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

Source: H312-A/20

Status: 1990; 1995 Reaffirmed as Amended; 2000 Reaffirmed, 2005 Reaffirmed; 2010 Reaffirmed; 2015 Reaffirmed as Amended; 2020 Reaffirmed

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Postgraduate Compensation

Policy Statement

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

Source: H313-A/20

Status: 1990; 1995 Reaffirmed as Amended; 2000 Reaffirmed, 2005 Reaffirmed as Amended; 2010 Reaffirmed; 2015; 2020 Reaffirmed as Amended

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Second Opinion, Surgical Cases

Policy Statement

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

Source: H314-A/20

Status: 1980; 1985 Reaffirmed as Amended; 1990 Reaffirmed; 1995 Reaffirmed; 2000 Reaffirmed as Amended; 2005 Reaffirmed as Amended; 2010 Reaffirmed as Amended; 2015 Reaffirmed as Amended; 2020 Reaffirmed

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Uniformed Services: Endorsement of Physicians Serving in the Uniformed Services

Policy Statement

The American Osteopathic Association (AOA) will continue to assist the Surgeons General of the uniformed services and the American public in maintaining and assuring the highest quality of healthcare by its representatives in the uniformed services and recognizes the annual anniversary of osteopathic physicians being commissioned in the military.

Source: H315-A/20

Status: 1985; 1990 Reaffirmed as Amended; 1995 Reaffirmed; 2000 Reaffirmed; 2005 Reaffirmed; 2010 Revised; 2015 Revised; 2020 Reaffirmed as Amended

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Emergency Medical Services for Children - Support of

Policy Statement

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

Source: H316-A/20

Status: 2005, 2010 Reaffirmed; 2015 Reaffirmed as Amended; 2020 Reaffirmed as Amended

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Physician Incentives to Underserved Areas

Policy Statement

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

Source: H317-A/20

Status: 2005; 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

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Medicare Balance Billing

Policy Statement

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

Source: H319-A/20

Status: 2010; 2015 Reaffirmed; 2020 Reaffirmed as Amended

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Prescription Drug Diversion and Abuse – Education, Research, and Advocacy

Policy Statement

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

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

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

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

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

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

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

Source: H322-A/20

Status: 2015; 2020 Reaffirmed

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Buprenorphine Maintenance Treatment Insurance Coverage

Policy Statement

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

Source: H323-A/20

Status: 2015; 2020 Reaffirmed

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Violence Against Healthcare Staff

Policy Statement

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

Source: H324-A/20

Status: 2015; 2020 Reaffirmed as Amended

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Low Back Pain Clinical Practice Guidelines - Revision of

Policy Statement

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

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

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

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

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

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

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

ABSTRACT

Background
Osteopathic manipulative treatment (OMT) is a distinctive modality commonly used by osteopathic physicians to complement conventional treatment of musculoskeletal disorders, including those that cause low back pain. OMT is defined in the Glossary of Osteopathic Terminology as: "The therapeutic application of manually guided forces by an osteopathic physician (US Usage) to improve physiologic function and/or support homeostasis that has been altered by somatic dysfunction. OMT employs a variety of techniques" (see Appendix 1 for list). Somatic dysfunction is defined as: "Impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial and myofascial structures, and their related vascular, lymphatic, and neural elements. Somatic dysfunction is treatable using osteopathic manipulative treatment."

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

Methods

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

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

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

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

Results

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

OMT significantly reduces pain and improves functional status in patients, including pregnant and postpartum women, with nonspecific acute and chronic LBP. Franke et al found that in acute and chronic non-specific LBP, moderate-quality evidence suggested OMT had a significant effect on pain relief (MD:-12.91, 95% CI: -20.00 to -5.82) and functional status (SMD:-0.36, 95%CI: -0.58 to -0.14). More specifically, in chronic nonspecific LBP, evidence suggested a significant difference in favor of OMT regarding pain (MD:-14.93, 95%CI:-25.18 to -4.68) and functional status (SMD:-0.32, CI:-0.58 to -0.07). When examining nonspecific LBP in pregnancy, low-quality evidence suggested a significant difference in favor of OMT for pain (MD, -23.01; 95% CI, -44.13 to -1.88) and functional status (SMD, -0.80; 95% CI, - 1.36 to -0.23). Conversely for nonspecific LBP postpartum, Franke et al found that moderate-quality

evidence suggested a significant difference in favor of OMT for pain (MD, -41.85; 95% CI, -49.43 to -34.27) and functional status (SMD, -1.78; 95% CI, -2.21 to -1.35).[2]

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

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

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

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

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

BACKGROUND
Historically, low back pain has been the most common reason for visits to osteopathic physicians.[3] More recent data from the Osteopathic Survey of Health Care in America has confirmed that a majority of patients visiting osteopathic physicians continue to seek treatment for musculoskeletal conditions.[4, 5] A distinctive element of low back care provided by osteopathic physicians is osteopathic manipulative treatment (OMT). A comprehensive evaluation of spinal manipulation for low back pain undertaken by the Agency for Health Care Policy and Research in the United States concluded that spinal manipulation can be helpful for patients with acute low back problems without radiculopathy when used within the first month of symptoms.[6]Nevertheless, because most studies of spinal manipulation involve chiropractic or physical therapy,[7]it is unclear if such studies adequately reflect the efficacy of OMT for low back pain. Although the professional bodies that represent osteopaths, chiropractors, and physiotherapists in the United Kingdom developed a spinal manipulation package consisting of three common manual elements for the UK Back pain Exercise and Manipulation (UK BEAM) trial,[8] there are no data on the comparability of profession specific outcomes.[9,10] It is well known that OMT comprises a diversity of techniques.[11] These OMT techniques are not adequately represented by the UK BEAM trial package. Professional differences in spinal manipulation are more pronounced in research studies, in which chiropractors have focused almost exclusively on high-velocity-low amplitude techniques.[12] For example, a major trial of chiropractic manipulation as adjunctive treatment for childhood asthma used a high-velocity-low amplitude thrust as the active treatment.[13] The simulated treatment provided in the sham manipulation arm of this chiropractic trial, which ostensibly was used to provide no therapeutic effect, bore a marked similarity to OMT.[12, 14] Because differences in professional background and training

lend themselves to diverse manipulation approaches, clinicians have been warned about generalizing the findings of systematic reviews to practice.[15] In additional to professional differences in the manual techniques themselves, osteopathic physicians in the United States, unlike allopathic physicians or chiropractors, can treat this condition simultaneously using both conventional primary care approaches and complementary spinal manipulation. This represents a unique philosophical approach in the treatment of low back pain. Consequently, there is a need for empirical data that specifically address the efficacy of OMT for conditions such as low back pain.[16]

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

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

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

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

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

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

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

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

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

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

This project was funded by the American Osteopathic Association. The AOA Bureau of Osteopathic Clinical Education and Research convened a Task Force on the Low Back Pain

Clinical Practice Guidelines to revise the guidelines. Upon approval of these recommendations by the AOA Board of Trustees and the AOA House of Delegates, the guidelines will be submitted to the National Guidelines Clearinghouse for public record and access. As the guidelines were developed based on the peer reviewed scientific literature, no conflict of interest is claimed by the developers. A well rounded, objective perspective is presented. Any views from an osteopathic perspective that is not supported by the scientific literature is stated and clearly identified so the reader is able to discern any potential for bias.

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

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

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

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

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

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

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

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

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

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

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

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

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

OMT versus other interventions for chronic nonspecific low back pain

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

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

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

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

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

OMT versus untreated for nonspecific low back pain in postpartum women

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

DISCUSSION

Efficacy of OMT

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

Licciardone et al [27], in the Osteopathic Health outcomes In Chronic low back pain (OSTEOPATHIC) Trial studied OMT and ultrasound therapy for short term relief of nonspecific chronic low back pain. The authors found that the patients receiving OMT showed moderate to

substantial improvements in low back pain which met or exceeded the Cochrane Back Review Group criterion for a medium effect size in relieving chronic low back pain.

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

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

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

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

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

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

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

Table 1. Levels of Evidence

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

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

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

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

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

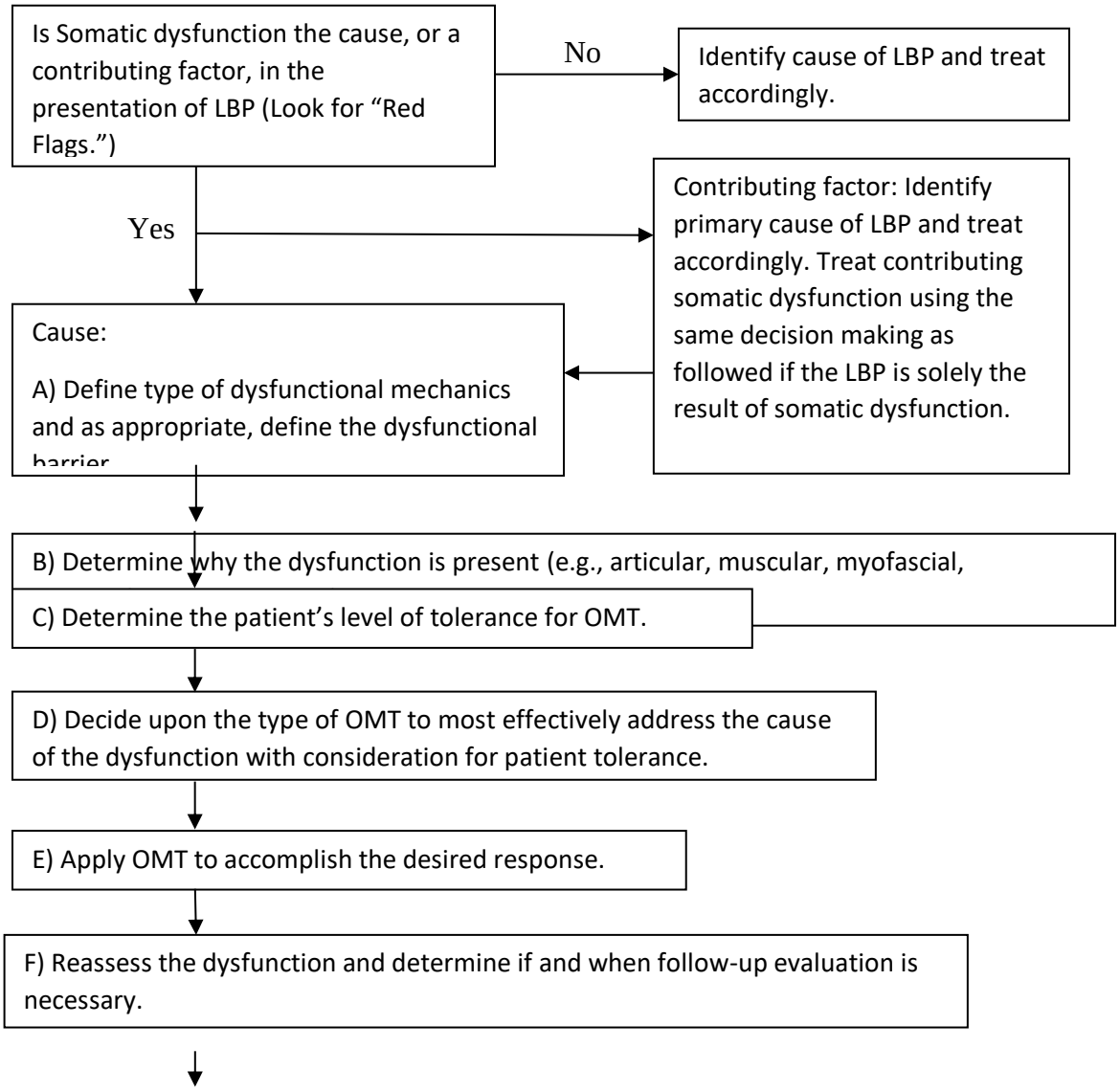
16. Patient preferences: Describe the role of patient preferences when a recommendation involves a substantial element of personal choice or values.

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

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

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

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



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

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

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

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Appendix 1

DEFINITION OF TERMS USED

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

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

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

> **active method,** technique in which the person voluntarily performs an osteopathic practitioner-directed motion.
>
> **articulatory treatment,** (Archaic). See *osteopathic manipulative treatment, articulatory treatment system.*
>
> **articulatory (ART),** a low velocity/ moderate to high amplitude technique where a joint is carried through its full motion with the therapeutic goal of increased range of movement. The activating force is either a repetitive springing motion or repetitive concentric movement of the joint through the restrictive barrier.
>
> **balanced ligamentous tension (BLT),** 1. According to Sutherland's model, all the joints in the body are balanced ligamentous articular mechanisms. The ligaments provide

proprioceptive information that guides the muscle response for positioning the joint, and the ligaments themselves guide the motion of the articular components. (*Foundations*) 2. First described in “Osteopathic Technique of William G. Sutherland,” that was published in the *1949 Year Book of Academy of Applied Osteopathy.* See also *ligamentous articular strain.*

Chapman reflex, See *Chapman reflex.*

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

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

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

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

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

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

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

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

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

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

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

facilitated positional release (FPR), a system of indirect myofascial release treatment. The component region of the body is placed into a neutral position, diminishing tissue

and joint tension in all planes, and an activating force (compression or torsion) is added. 2. A technique developed by Stanley Schiowitz, DO.

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

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

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

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

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

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

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

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

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

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

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

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

liver pump, See *hepatic pump.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

somatic dysfunction: Impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial and myofascial structures, and their

related vascular, lymphatic, and neural elements. Somatic dysfunction is treatable using osteopathic manipulative treatment.

Appendix 2

References cited in Franke et al systematic review

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Source: H325-A/20

Status: 2009; 2014 Referred; 2015 Reaffirmed as Amended; 2020 Reaffirmed as Amended

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Adverse Childhood Experiences Screening

Policy Statement

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

Source: H327-A/20

Status: 2020 Adopted as Amended

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Inequalities in Medicaid Funding Affecting U.S. Territories

Policy Statement

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

Source: H329-A/20

Status: 2020 Adopted as Amended

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

Policy Statement

The American Osteopathic Association (AOA) adopts as policy:

(1) that AOA members are encouraged to use the terms “physician” or “doctor” to describe themselves, leaving other terms such as “practitioner,” “clinician,” or “provider” to be used by non-physician clinicians or to categorize health care professionals as a whole;

(2) supports the appropriate use of credentials and professional degrees in advertisements;

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

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

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

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

Source: H336-A/20

Status: 2009; 2014 Reaffirmed as Amended; 2020 Reaffirmed

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CDC Guideline for Prescribing Opioids for Chronic Pain — United States

Policy Statement

The American Osteopathic Association (AOA) opposes the misuse and inflexible application of the United States Centers for Disease Control and Prevention (CDC) "Guideline for Prescribing Opioids for Chronic Pain — United States, 2016, (Guidelines) by law makers and regulators; and the AOA opposes the codification of the Guidelines into law or regulation and their use as a measure of the appropriateness of physicians prescribing; and the AOA recommends physicians read and consider the use of the 2019 AMA Opioid Task Force 2019 Guidelines4 in patients being treated for non-malignant chronic pain conditions.

Source: H337-A/20

Status: 2020

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Medication for Opioid Use Disorder (MOUD) Availability for Incarcerated Individuals and/or Individuals Under Correctional Control

Policy Statement

The American Osteopathic Association will support the administration and/or prescribing of all FDA-approved treatments for opioid use disorder (OUD) for all individuals with OUD who are incarcerated or under other forms of governmental or private correctional control.

Source: H300-A/21

Status: 2021

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Availability of Modalities of Prescribing
Policy Statement

The American Osteopathic Association advocates for all methods of prescribing by physicians for schedule II through schedule V controlled substances including fax, telephone, print, EPCS (Electronic Prescriptions for Controlled Substances) and hand-written prescriptions that meet the United States Drug Enforcement Administration guidelines and applicable federal and state laws and regulations for a valid controlled substance prescription.

Source: H301-A/21

Status: 2021

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Direct Acting Therapy for Hepatitis C Limitations
Policy Statement

The American Osteopathic Association supports elimination of specialty-based, physician prescribing limitations of direct acting antiviral treatments for Hepatitis C.

Source: H303-A/21

Status: 2021

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Increasing Voter Access for Hospitalized Patients
Policy Statement

The American Osteopathic Association (AOA) supports access to voting for hospitalized patients.

Source: H305-A/21

Status: 2021

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Support of Continued Funding for Corporation for National and Community Service (CNCS) Policy Statement

The American Osteopathic Association (AOA) supports continued federal funding for Corporation for National and Community Service (CNCS) programs.

Source: H306-A/21

Status: 2021

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Appropriate PPE Usage Provisions

Policy Statement

The American Osteopathic Association (AOA) supports evidence-based standards and national guidelines regarding the use, reuse, and proper decontamination of personal protective equipment (PPE), especially in circumstances of increased demand. The AOA will advocate for the utmost protection of all healthcare personnel, emphasizing the responsibility of the healthcare institution to provide sufficient PPE within reasonable measures.

Source: H307-A/21

Status: 2021

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Intractable and/or Chronic Pain (Not Associated with End of Life Care)

Policy Statement

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

Definitions:

A. Intractable pain means a pain state in which the cause of the pain cannot be removed or otherwise definitively treated and which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, a face-to-face evaluation by the attending physician and/or other physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain. Chronic non-malignant pain may be associated with a long-term incurable or intractable medical condition or disease.[1]

Chronic pain means "pain that typically lasts >3 months or past the time of normal tissue healing. chronic pain can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or an unknown cause."[2]

Provisions:

A. Notwithstanding any other provision of law, a physician may prescribe or administer controlled substances to a person in the course of the physician's treatment of the person for a diagnosed condition causing intractable and/or chronic pain. This includes patients with chemical dependency and/or substance abuse history if chronic pain exists and controlled substance management is indicated. Physician hypervigilance in screening for drugs of abuse, as well as the presence of the treatment medication in these patients is necessary.

B. No physician shall be subject to adverse action (by the state medical board, employers, insurers, etc.) for appropriately prescribing or administering controlled substances in the course of treatment of a person for intractable pain and/or chronic pain.

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[1] See MN 152.125 Intractable Pain; TX Sec. 107.001 Intractable Pain Treatment Act; FL 458.326 Intractable Pain – Authorized Treatment.

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

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

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

E. This section is not intended to interfere with the power (of the state medical board) to deny, revoke, or suspend the license of any physician who fails to keep accurate records of purchases and disposal of controlled substances, writes false or fictitious prescriptions for controlled substances, or prescribes, administers, or dispenses in violation of state controlled substances acts.

Source: H308-A/21

Status: 2021

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Center of Excellence for Stroke

Policy Statement

The American Osteopathic Association encourages practitioners and healthcare institutions, through certification and streamlined coordinated quality patient centered care, to develop stroke centers of excellence to improve the healthcare quality for US citizens.

Source: H313-A/21

Status: 2011, 2016 Reaffirmed; 2021 Reaffirmed as Amended

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Voting Day – AOA Supports Voting Day Policy

Policy Statement

The American Osteopathic Association encourages all osteopathic physicians to adopt voting policies in their workplaces that would allow their employees time off during working hours, if necessary, to participate in voting for local, state, and national elections.

Source: H314-A/21

Status: 1991; 1996 Reaffirmed as Amended; 2001 Reaffirmed; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed

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Patient Care at Extended Long Term Care Facilities

Policy Statement

The American Osteopathic Association encourages the Centers for Medicare and Medicaid Services (CMS) and any other regulatory and non-regulatory entity to: (1) re-evaluate their payment policy to encourage appropriate and adequate care to occur at extended long term care facilities; (2) improve payment to physicians for patient care in extended long term care facilities and to reimburse time spent on phone calls and care plan oversight from extended long term care facilities to physicians; (3) encourage physicians to participate in treatment of their patients at their respective extended long term care facilities; and (4) encourage appropriate tort reform to eliminate less than meritorious claims of elder abuse and malpractice in extended long term care facilities.

Source: H315-A/21

Status: 2006; 2011 Reaffirmed as amended; 2016 Reaffirmed as Amended; 2021 Reaffirmed

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Osteopathic Term Protection

Policy Statement

The American Osteopathic Association's policy regarding the preferential terms to be used in reference to the osteopathic profession has been updated over the years. However, we are mindful that there are osteopathic physicians practicing medicine who were granted degrees in "osteopathy." Therefore, the AOA will continue to advocate for the protection of the terms "osteopathic", "osteopathy" and "osteopath" as referenced in state and federal laws and rules.

Source: H316-A/21

Status: 2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed

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Cyberbullying through Social Media

Policy Statement

The American Osteopathic Association supports increasing awareness among parents / guardians, caregivers, educators, counselors and physicians about the danger of cyberbullying through media advocacy efforts and encourages osteopathic physicians to talk to their patients and the parents / guardians of their patients about cyberbullying and the lasting emotional damage that it can cause.

Source: H317-A/21

Status: 2011; 2016 Reaffirmed; 2021 Reaffirmed

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Firearms – Commission of a Crime while using a Firearm

Policy Statement

The American Osteopathic Association supports the position that persons accused of a crime involving a firearm be prosecuted to the full extent of the law.

Source: H318-A/21

Status: 1994; 1996 Reaffirmed as Amended; 2001 Reaffirmed; 2006 Reaffirmed; 2011 Reaffirmed as Amended 2011; 2016 Reaffirmed; 2021 Reaffirmed

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Good Samaritan Acts (Hold Harmless Agreement) Performed on Commercial Aircraft

Policy Statement

The American Osteopathic Association strongly recommends that all counties and states recognize Good Samaritan (Hold Harmless) laws for medical care rendered on commercial aircraft and urges all airlines to provide liability coverage for such medical care; and will petition the Federal Aviation Administration and appropriate international aviation entities to adopt such standards for all commercial airlines.

Source: H319-A/21

Status: 2001; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed

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Medicaid Pharmaceutical Benefits

Policy Statement

The American Osteopathic Association should support federal and state policies that ensure Medicaid beneficiaries have access to high-quality health care at the same level of non-Medicaid beneficiaries, to include all healthcare services and products including relevant pharmaceuticals, medical devices, and therapies.

Source: H320-A/21

Status: 1996; 2001 Reaffirmed as Amended; 2006 Reaffirmed; 2016 Reaffirmed as Amended; 2021 Reaffirmed as Amended

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Medical Shortages

Policy Statement

The American Osteopathic Association will work with the Federal Government, pharmaceutical and medical supply manufacturers, and hospital organizations to ensure that any interruptions of the medical supply chains are as limited in depth and breadth as possible.

Source: H321-A/21

Status: 2016; 2021 Reaffirmed as Amended

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Health Insurance Availability to Osteopathic Medical Students

Policy Statement

The American Osteopathic Association will advocate for subsidized and more affordable healthcare for Osteopathic Medical Students for the duration of their education.

Source: H322-A/21

Status: 2016; 2021 Reaffirmed

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Behavioral Health Services – Funding and Access

Policy Statement

The American Osteopathic Association (AOA) supports legislative and other efforts to ensure adequate funding of behavioral health services and will support actions, including federal, state or local legislation or regulation, that improve access to and continuity of behavioral health care services in local communities and that maintain stability of established patient-physician relationships.

Source: H323-A/21

Status: 2016; 2021 Reaffirmed as Amended

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Physician Gag Rules – Opposition to

Policy Statement

The American Osteopathic Association (AOA) is opposed to governmental actions and policies that limit the rights of physicians and other health care practitioners to inquire of their patients whether they possess guns and how they are secured in the home or to counsel their patients about the potential dangers of guns in the home and safe practices to attempt to avoid those potential dangers. The AOA opposes any further legislation or initiatives advocating physician gag rules that limit physicians' right to free speech or other rights.

Source: H324-A/21

Status: 2016; 2021 Reaffirmed

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Congressional Budget Office Fiscal Scoring

Policy Statement

The American Osteopathic Association supports the adoption of a dynamic fiscal scoring by the Congressional Budget Office for health policy legislation.

Source: H325-A/21

Status: 2016; 2021 Reaffirmed as Amended

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Pain Related Education Requirements

Policy Statement

The American Osteopathic Association will advocate for medical education for all practitioners on proper opioid prescribing practices and any state mandated pain education requirements should include proper prescribing practices for opioids relating to pain treatment, opioid addiction, and identification of prescription drug abuse, misuse and diversion.

Source: H326-A/21

Status: 2016; 2021 Reaffirmed as Amended

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Non-Physician Health Care Clinician

Policy Statement

The American Osteopathic Association will request of congress and regulatory bodies that the title “health care provider” not be used in favor of the title “physician and non-physician clinician.”

Source: H327-A/21

Status: 2016; 2021 Reaffirmed

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Tricare Health Insurance for our Military

Policy Statement

The American Osteopathic Association supports member participation in TRICARE plans to provide care for all armed service members, active or reserve, retirees, and their families.

Source: H329-A/21

Status: 2016; 2021 Reaffirmed

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Osteopathic Manipulative Treatment (OMT) in Chronic Pain Management Guidelines – Inclusion of

Policy Statement

The American Osteopathic Association (AOA) will educate the public and policymakers about the efficacy and cost-effectiveness of osteopathic manipulative treatment (OMT) and advocate for OMT as a clinically effective and cost-effective intervention for the treatment of chronic nonmalignant pain syndromes. The AOA will advocate for the inclusion of specific language regarding OMT in recommendations for non-pharmacological interventions for chronic nonmalignant pain syndromes.

Source: H330-A/21

Status: 2016; 2021 Reaffirmed as Amended

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Support of Breastfeeding

Policy Statement

The American Osteopathic Association supports all hospitals and birth centers to provide mothers the information and skills to initiate and continue breastfeeding their babies.

Source: H331-A/21

Status: 2011; 2016 Reaffirmed; 2021 Reaffirmed as Amended

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Organ and Tissue Donation and Transplantation Initiatives – Commitment to

Policy Statement

The American Osteopathic Association (AOA) affirms its support for organ and tissue donation and transplantation programs at local and national levels; will develop and continue to promote physician and public education programs to advance the cause of organ and tissue donation and transplantation; urges the Osteopathic Family to volunteer personally as organ and tissue donors, and in turn, actively encourage their patients to do the same; and encourages osteopathic divisional and specialty organizations, osteopathic medical colleges, and other members of the osteopathic family to develop organ and tissue donation programs in their states and organizations. The AOA also affirms its support for blood donation on an ongoing basis. Furthermore, the AOA is opposed to the sale of donated organs and tissues outside of the United States, and opposed to the sale of organs and tissues for profit.

Source: H332-A/21

Status: 2001; 2006 Reaffirmed; 2011 Reaffirmed; 2016 Reaffirmed as Amended;
2021 Reaffirmed

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Vaccine Supply and Distribution

Policy Statement

The American Osteopathic Association shall actively advocate for federal policies that support activities and processes for monitoring the supply of vaccines and coordinating vaccine supply and preferentially direct vaccines to physicians, healthcare facilities and healthcare agencies before they are made available to retail outlets.

Source: H333-A/21

Status: 2001; 2006 Reaffirmed as Amended; 2011 Reaffirmed as Amended;
2016 Reaffirmed as Amended; 2021 Reaffirmed

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Health Literacy

Policy Statement

The American Osteopathic Association strongly supports the campaign for health literacy and encourages all practitioners and medical facilities to create a shame-free environment where low-literate patients can seek help.

Source: H334-A/21

Status: 2011; 2016 Reaffirmed; 2021 Reaffirmed

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Onsite Lab Work No. 1

Policy Statement

The American Osteopathic Association supports the adoption of national legislation payment and regulation that enables the physician to perform and be compensated for CLIA certified in-office laboratory tests and supports the adoption of national legislation such policies which enables the physician to perform and be appropriately compensated for medically indicated on-site diagnostic procedures.

Source: H335-A/21

Status: 1999; 2004 Reaffirmed; 2016 Reaffirmed as Amended; 2021 Reaffirmed

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Managed Care Referrals

Policy Statement

The American Osteopathic Association supports and promotes legislation that enables patient access to medical specialists by direct referral from the primary care physicians without preauthorization by the managed care company.

Source: H336-A/21

Status: 2001; 2006 Reaffirmed as Amended; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed

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Medicare Physician Payment for Osteopathic Manipulative Treatment

Policy Statement

The American Osteopathic Association advocates for nationwide consistency in Medicare physician's payment policy, as it relates to osteopathic manipulative treatment (OMT) and evaluation and management (E/M) services, leading to payment for OMT as a separately identifiable procedure from the E/M in all contract regions.

Source: H337-A/21

Status: 1991; 1996 Reaffirmed as Amended; 2001 Reaffirmed; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed as Amended; 2021 Reaffirmed

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Drug Plan Coverage Denials

Policy Statement

The American Osteopathic Association will advocate to the appropriate regulatory agencies and other health professional organizations to require drug benefit managers to fully explain any denial of medication coverage, with explanations that must include but not be limited to the following: (1) The medical reason for denial of a prescribed medication; (2) The criteria upon which a reversal of the denial will be considered; (3) A listing within the notification of denial of the approved alternatives to the prescribed medication; and (4) Listing of appeals process for denials.

Source: H338-A/21

Status: 2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed

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Payor Adherence to Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) Coding Definitions

Policy Statement

The American Osteopathic Association will advocate for all payors to adhere to all CPT coding conventions in developing payment policies; and will support action to prevent payors from deviating from CPT definitions and promote autonomous, fair, and uniform interpretation of CPT and ICD codes to allow for non-prejudicial treatment by payors in the reimbursement arena.

Source: H339-A/21

Status: 2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed as Amended; 2021 Reaffirmed

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Interference – Lawful Off-Label Treatment of Patients

Policy Statement

The American Osteopathic Association (AOA) proactively support the protection of a physician's ability to prescribe treatments and to speak freely about lawful, evidence-based, health care options, including off-label treatments or health care-related research, without fear of being sanctioned by regulatory boards, insurance companies or employers.

The AOA supports state efforts to protect patients and prevent sanctions for physicians, directly or indirectly through a subcontractor or otherwise, for making a patient aware of or educating a patient about lawful, evidence-based, health care options, including 1) off-label use of health care options; 2) health care-related research or data; and 3) for offering, providing or making available lawful, evidence-based health care options.

Source: H340-A/21

Status: 2016; 2021 Reaffirmed

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Appropriate Payment Mechanisms for Physician-Led Team-Based Health Care

Policy Statement

The American Osteopathic Association (AOA) will strongly advocate for effective payment models that appropriately 1) incentivize high-quality care, and 2) ensure physicians receive payment for providing this care.

The AOA will advocate to the Centers for Medicare and Medicaid Services (CMS) that any alternative payment models (APMs) proposed for inclusion in Medicare Access and CHIP Reauthorization Act (MACRA) be reviewed through an administratively simple and transparent process, in a timely manner, and include an appeals process.

The AOA encourages public and private health insurers to develop a variety of value-based contracting options so that physician practices can select payment models that best suit their delivery of care.

Source: H341-A/21

Status: 2016; 2021 Reaffirmed as Amended

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Human Immunodeficiency Virus (HIV)

Policy Statement

In accordance with the American Osteopathic Association's Code of Ethics: (1) osteopathic physicians and osteopathic medical students should provide care for those at risk and those infected with Human Immunodeficiency Virus (HIV), in an atmosphere of compassion and nondiscrimination; (2) recognize their professional and ethical obligations to care for such patients as they care for all patients; (3) osteopathic physicians and osteopathic medical students in their important role as humanitarian resources to their patients, families, and communities, provide candid, effective nonjudgmental preventive education for those at risk, and serve as effective resources for their patients' families and loved ones; and (4) osteopathic physicians and osteopathic medical students should be educational resources for those at negligible risk in an effort to promote enlightened attitudes in places of work, our schools, and communities in general**;** and (5) osteopathic physicians and osteopathic medical students should advocate for the removal of legal and systemic barriers to allow patients living with HIV to access care, and to allow healthcare workers living with HIV to provide care to their patients

Source: H342-A/21

Status: 1992; 1996 Reaffirmed as Amended; 2001 Reaffirmed as Amended; 2006 Reaffirmed as Amended; 2011 Reaffirmed; 2016 Reaffirmed; 2021 Reaffirmed as Amended

AMERICAN OSTEOPATHIC ASSOCIATION

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White Paper – Improving Access to Physician Led Care

Policy Statement

The American Osteopathic Association adopted the white paper, Improving Access to Physician-Led Care as its position on leveraging the physician-led, team-based model of care to meet our nation's growing health care needs in a safe and cost-effective manner.

Improving Access to Physician-led Care

Overview

This paper addresses the primary care physician workforce shortage, identifying potential solutions dispels notions that scope of practice expansions can address the issue.

Background

Numerous factors contribute to the growing physician workforce shortage in the United States, currently projected to exceed 139,000 physicians by 2030.[1] These include an aging population (including among physicians), an increase in the number of insured individuals following the enactment of the Affordable Care Act (ACA) and related state Medicaid expansions, and the arbitrarily low cap on Medicare-funded graduate medical education (GME, aka "residency") positions for physicians that was established by Congress in 1997, as well as Medicare, Medicaid and other payor payment rates which have failed to keep pace with the increasing cost of providing care

According to a 2020 study published by the American Association of Medical Colleges, the United States population is expected to grow by 10.4% (from about 327 million to 361 million) by 2033, while the population over age 65 is expected to grow by 45.1%.[2] Further, more than 2 in 5 currently practicing physicians will reach retirement age in the next decade.[3] In addition, more than 20 million Americans gained insurance coverage over the past few years under the ACA. Further, if the states that have not expanded Medicaid eligibility (12 as of January 2021) did so, nearly 4 million more individuals would become eligible for coverage.[4] These factors combine to create an increasing demand for physician services, while two major factors work against a supply-side increase: (1) the freeze on Medicare funding and geographic distribution of residency slots at their 1996 levels and locations, and (2) rising educational debt that is

[1] X. Zhang, D. Lin, H. Pforsich, and V. W. Lin. 2020. Physician workforce in the United States of America: forecasting nationwide shortages. *Human Resources for Health.* Article, National Center for Biotechnology Information, Washington, DC.

[2] No author. June 2020. The Complexities of Physician Supply and Demand: Projections From 2018 to 2033. Association of American Medical Colleges. Report, IHS Markit Ltd., Washington, DC.

[3] *Id.*

[4] R. Garfield, K. Orgera and A. Damico. 2021. The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid. Issue Brief, Kaiser Family Foundation, San Francisco, CA.

leading physicians who might otherwise choose to practice in physician shortage areas or in high need specialties to seek higher paying specialty positions in urban areas.[5]

Legislative Proposals

In order to address the growing physician shortage, some legislators have begun electing to circumvent evidence-based physician licensure pathways to allow non-physician clinicians (nurses, physician assistants, and even entirely new types of clinicians) to practice equivalently to physicians without completing similar education, training or testing.

There are several issues with this approach; namely, (1) that unlike physicians, the length, content and type of training (online vs. in-person, didactic vs. clinical, academic vs. practical, etc.) that these providers complete varies by state and sometimes even by provider, (2) research demonstrates that these individuals are largely drawn to the same areas where physicians are already practicing, and that (3) non-physicians tend to overprescribe/overutilize diagnostic tests, which, combined with their history of seeking pay parity with physicians legislatively once they achieve independent practice, makes it unlikely that these individuals will actually solve the cost and access issues that legislators are attempting to address.

Physician licensure requirements are largely the same across states, and require four years of medical school, a comprehensive examination series followed by supervised postgraduate ("residency") training with progressively greater autonomy before they are allowed to independently treat patients. Medical school education is nationally standardized and includes two years of didactic study totaling upwards of 750 lecture/practice learning hours just within the first two years, plus two more years of clinical rotations done in community hospitals, major medical centers and doctors' offices. Residency programs are also standardized by specialty, and are comprised of 12,000 to 16,000 hours of supervised training through which physicians develop advanced knowledge and clinical skills relating to a wide variety of patient conditions over the course of three to seven years.

While physician licensure requirements remain largely the same across the country – and in fact, the trend has been towards *increasing* physician education and training requirements over the years – some states have begun granting similar licenses to non-physician clinicians, upon completion of as little as a two-year master's degree (which may be done largely online), a single examination and no supervised postgraduate training, as in the case of nurse practitioners (NPs).[6] Not only do NPs complete far fewer supervised clinical hours than physicians during their educational programs, their professional organization (the American Academy of Nurse Practitioners; "AANP") actually *opposes* requiring them to complete supervised residency training before becoming licensed to practice independently.[7] Unsurprisingly based on their relatively short educational background, evidence shows that non-physician clinicians tend to overprescribe medication[8], issue poorer quality referrals to

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[5] The Consolidated Appropriations Act, 2021 enacted into law on December 27, 2020, provides the Centers for Medicare & Medicaid Services funding for 1,000 new residency slots. This will support approximately 200 new Medicare-funded residency positions per year for five years.

[6] *See* Master of Science in Nursing in Family Nurse Practitioner, Texas A&M University. Accessed on April 5, 2021. Available at: https://catalog.tamu.edu/graduate/colleges-schools-interdisciplinary/nursing/msn-family-practitioner/#degree-plan.

[7] *See* Position Statement: Mandated Residency and Fellowship Training. *American Association of Nurse Practitioners*, 2019.

[8] U. Muench, J. Perloff, C. Parks Thomas and P. Buerhaus. Prescribing Practices by Nurse Practitioners and Primary Care Physicians: A Descriptive Analysis of Medicare Beneficiaries. *Journal of Nursing Regulation*, April 1, 2017.

specialists[9] and order unnecessary diagnostic imaging[10] compared to physicians, all of which expose patients to potentially costly, unnecessary and high-risk interventions, because their training has not prepared them to determine which cases warrant such care.

Some states have also begun allowing non-physician clinicians who complete doctorates to refer to themselves as "doctors" regardless of whether the doctorate that they completed is academic rather than clinical in nature. Use of the title "doctor" in a clinical setting can easily confuse patients into thinking that they are being seen by a physician when the individual making medical decisions has vastly different education and training.[11]

Despite these differences in education, training and testing, history shows that once non-physician clinicians achieve independent practice they often return to state legislatures to advocate for pay parity with physicians, thereby defeating any cost savings arguments for independent practice. [12] All health care professions have an equal right to provide stakeholder input to the Centers for Medicare & Medicaid Services (CMS), which makes centralized decisions regarding health professional payment rates after taking into account factors such as the time it takes to perform a service, the technical skill and physical effort, the required mental effort, judgment and stress due to the potential risk to the patient, as well as practice expenses and professional liability insurance costs. Nonetheless, pay parity is a stated goal of organizations like the AANP, and their success achieving it legislatively rather than through evidence-based valuation protocols may encourage other non-physician clinician associations to seek similar rate increases from state legislatures. When combined with these providers' overutilization of costly medical procedures and prescriptions, it is unlikely that granting independent practice will have a positive impact on healthcare cost issues.[13]

In addition to cost concerns, research demonstrates that allowing non-physician clinicians to practice independently does not solve access-to-care issues either. In fact, it shows that these individuals largely choose to practice in areas where physicians are already practicing.[14] To avoid this, some states have attempted to place initial geographic and practice area (i.e. primary care only) limits on a provider group in order to improve access in rural areas; however, historical trends show that once independent practice is achieved, these groups return to the legislature year after year in attempts to erode any remaining restrictions on their practice.[15] These patterns demonstrate that while the stated goal of these groups may be to address cost and access issues, their true motivation is a desire to achieve similar practice rights and reimbursement to physicians without having to complete similar training and testing requirements that help to ensure patient safety.

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[9] R. Lohr, C. West, M. Beliveau, et al. Comparison of the Quality of Patient Referrals from Physicians, Physician Assistants, and Nurse Practitioners. Mayo Clinic Proceedings, Oct. 11, 2013.

[10] D. Hughes, M. Jiang and R. Duszak Jr. A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. *JAMA Internal Medicine*, January 2015.

[11] *See* DNP-PhD Comparison, Duke University School of Nursing. Accessed on April 5, 2021. Available at: https://nursing.duke.edu/academic-programs/dnp-program-nursing/dnp-phd-comparison.

[12] L. Kaplan, Louise and J. Gill. Advocating for Washington state ARNP payment parity. *The Nurse Practitioner*, Feb. 2020.

[13] *See* https://www.aanp.org/news-feed/the-american-association-of-nurse-practitioners-aanp-is-now-100-000-strong.

[14] *See* sample NP workforce maps for Wyoming, Delaware.

[15] *See* e.g. Massachusetts - 244 CMR 4.00 of 2012 (established independent practice for certified nurse midwives) and MA House Bill 552 of 2017-18 and MA House Bill 1028 of 2019-2020 (seek payment parity)

A Better Way: the Physician-led, Team-based Model of Care

Rather than the fragmented, two-tiered healthcare system described above, studies show that the optimal way to deliver high quality, cost-effective medical care is through a team-based model that utilizes the various strengths of each member of the healthcare team with a physician at the head.

A recent study by the National Academy of Medicine (NAM) found that "multidisciplinary team-based care is associated with better performance on traditional measures of health care quality, such as emergency department utilization and hospital readmissions. In addition, several studies have concluded that optimizing team-based care is a cost-effective intervention."[16] These findings are consistent across settings, including ambulatory emergency departments, intensive care units, and nursing homes, as well as other settings. Among the research cited in the NAM analysis, a 2015 review of 52 studies of team-based care for hypertension found that teams achieved controlled blood pressure in 12 percent more patients than routine care did. They also cite another study finding that a team-based care model "that works in collaboration with primary care clinicians and patient-centered medical homes to provide home-based geriatric care management was associated with 7.1 percent fewer emergency department visits, 14.8 percent fewer 30-day readmissions, 37.9 percent fewer hospital admissions, and 28.5 percent fewer total bed days of care, saving an estimated $200,000 per year after accounting for program costs."

The best approach to improving healthcare quality while expanding system capacity is through expanding a physician and non-physician clinician workforce that is effectively trained in team-based care. Authorizing independent practice for non-physician clinicians is counterproductive to this effort, insufficiently supported by evidence, and potentially harmful to patient outcomes. There have been few randomized control trials (RCTs) assigning patients to different providers to compare cost and quality between physicians and non-physician clinician groups. Most studies have relied on analyses of claims and encounter data, and the few RCTs that have been conducted were plagued with serious methodological flaws.

A June 2019 Medicare Payment Advisory Commission (MedPAC) report to Congress noted that practices that employ both NPs or physician assistants (PAs) and physicians might systematically direct lower acuity patients to NPs or PAs. Patients may also choose among physicians, NPs, and PAs based on their preferences or the perceived severity of their illness. To the extent that systematic differences exist in the types of patients treated by physicians compared with those treated by NPs or PAs that are not observable in the data (and thus cannot be adjusted for), these studies may not effectively isolate the effects of clinician type from other confounding factors.

Additionally, the roles and responsibilities of nurses can vary in different settings, and definitions of autonomy varied between some RCTs conducted. An analysis published in 2014 found that "[i]n the evaluated studies, the assumption is that nurses possess the competence required for substituting physicians, but the level of substitution does not seem equal among studies. While the level of training may be a critical factor for an effective outcome, the studies report

[16] Smith, C. D., C. Balatbat, S. Corbridge, A. L. Dopp, J. Fried, R. Harter, S. Landefeld, C. Martin, F. Opelka, L. Sandy, L. Sato, and C. Sinsky. 2018. Implementing optimal team-based care to reduce clinician burnout. *NAM Perspectives.* Discussion Paper, National Academy of Medicine, Washington, DC.

incomplete descriptions of nurses' roles and competencies".[17] Among the few RCTs that have been conducted, long-term outcomes and condition management for complex cases are also not sufficiently accounted for.

An analysis published in the *International Journal for Quality in Health Care* in 2015 describes the limitations encountered in their analysis, stating that "the physiologic outcomes addressed in current research focused on changes in parameters such as blood pressure; a more meaningful outcome would be the proportion of subjects attaining disease control over time. Future studies should also examine rates of preventable hospitalizations and appropriate preventive care, such as vaccines and disease screening. Finally, studies with longer follow-up periods will allow for assessment of rates of retention in care".[18] A consistent concern among existing RCTs is the length of the follow-up period and the outcomes tracked over that period. Often, studies comparing advanced practice registered nurses and physicians have been limited to a single encounter or one month time frame.[19]

The growing responsibilities that non-physician clinicians take on in our health care system, especially within collaborative care models, are critical. However, this is not sufficient to justify scope of practice expansions that can negatively impact patient care. While numerous studies highlight the quality of care provided by non-physician clinicians, it is critical to also recognize the shortcomings of the research and factors that they have been unable to account for.

Additionally, while not well-documented, it is self-evident that that there is more fragmented care where independent practice for non-physicians exists, and physicians are often called upon following an initial misdiagnosis or negative outcome resulting from care from a lesser-trained clinician.

Evidence-based Solutions

Targeted Funding

The cost to produce a physician in the U.S. is staggering, and recent studies show that 76 percent of all medical school graduates graduate with student loans, averaging approximately $190,000. With interest growing over the course of a three-to-seven-year residency program, the eventual repayment total for many physicians can exceed $400,000.[20] Recognizing the importance of a physician-lead medical workforce, a number of states have implemented successful graduate medical education and loan repayment programs that can serve as models for other states to help them attract physicians to provide care in much-needed specialties and areas.[21]

One recent example is Oregon's Health Care Provider Incentive Fund (Fund), which was established in 2017 through an initial $16 million allocation to build health care workforce capacity in rural and medically underserved parts of Oregon and to provide resources for the

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[17] Martinez-Gonzalez et al. "Substitution of physicians by nurses in primary care: a systematic review and meta-analysis". *BMC Health Services Research*. 2014, 14:214.

[18] Swan et al. "Quality of primary care by advanced practice nurses: a systematic review". *International Journal for Quality in Health Care*. 2015 Oct;27(5):396-404. doi: 10.1093/intqhc/mzv054.

[19] Id.

[20] M. Runge. Public service loan forgiveness can help fix the shortage of primary care and rural physicians. *STAT+,* August 11, 2017.

[21] No author. Loan Repayment/Forgiveness/Scholarship and Other Programs. *Association of American Medical Colleges*, no date.

Health Care Provider Incentive Program (HCPIP).[22] The funding is administered by the Oregon Health Authority (OHA) in partnership with the Oregon Office of Rural Health (OORH), and utilizes loan forgiveness, loan repayment, insurance subsidies and scholarships (including one at the Pacific Northwest College of Osteopathic Medicine) to assist qualified health care providers who commit to serving the state's Medicaid and Medicare beneficiaries for a certain period of time in rural and underserved areas of the state.

Specifically, the primary care loan forgiveness program provides loans to postgraduate trainees who agree to:

1. Practice for one to three years in an underserved Oregon community that has been federally defined as a Health Professional Shortage Area (HPSA), and

2. Serve Medicaid and Medicare members in at least the same percent as is present in the community.

If the provider still has debt upon completion of the program, they then become eligible for a loan repayment award.

In addition, the HCPIP also provides subsidies for malpractice insurance premiums for providers serving at a location that meets the OHA's definition of a rural practice. Subsidy payments from OHA are a percentage of the provider's malpractice premiums, with the highest subsidies awarded to providers of obstetrical care.

Lastly, the HCPIP funds scholarship awards at schools equal to the cost of a year of education, in exchange for a 1-year HPSA service obligation for each year funded.

As a result of these incentives, nine of the 16 areas identified as "target areas" for the program in 2018 have seen an increased number of full-time providers. A program evaluation identified COVID-19 as an obstacle to the growth and sustainability of the program in the last year; however, the program has adjusted to account for the increased use of telemedicine among awardees and also plans to increase targeted outreach to clinicians who are representative of those they serve to improve the program's reach to marginalized communities.

Another example of state success – as well as the negative impact associated with cutting funding for training programs – is the state of Texas, which has provided varying levels of funding for rural and primary care training programs through its Higher Education Coordinating Board (THECB) since the 1980s. Funded programs include:

- The Statewide Primary Care Preceptorship Program, which provides funding support to preceptorship programs in family practice, general internal medicine and general pediatrics, with the goal of encouraging Texas medical students to choose primary care careers by offering direct student support for a month-long experience in one of the specialties. A comprehensive nine-year study showed that students who participated in a family medicine preceptorship were almost twice as likely to pursue a career in family medicine, and of the 238 medical students who completed the preceptorships in 2009, 93 percent said the experience made them more receptive to primary care as a career[23];

[22] No author. Health Care Provider Incentive Program: Evaluation of Program Effectiveness. *Oregon Health Authority, Health Policy and Analytics Division, Primary Care Office*, Nov. 2020.

[23] https://www.tafp.org/Media/Default/Downloads/advocacy/Support_PC_residencies.pdf

- The Physician Education Loan Repayment Program, which provides loan repayment funds for physicians who agree to provide health care services to recipients enrolled in Medicaid and the Texas Children's Health Insurance Program (CHIP), or in a Texas Juvenile Justice Department or Texas Department of Criminal Justice facility, for at least four years;

- The State Rural Training Track Grant Program, which provides funding for residency programs in rural areas, with the goal of attracting physicians to remain in those areas to practice; and

- The Family Practice Residency Program, which provides grants to the state's 31 nationally accredited family medicine residency programs, located in every region of the state, in order to help increase the number of physicians who pursue family medicine and establish their practices in rural and underserved communities in Texas.[24]

Although 66 percent of the physicians who completed residency training in Texas between 2008 – 2017 chose to remain in the state upon completion[25] – indicating a high return on investment for the aforementioned programs – funding has been variable and over the years some programs have been forced to close permanently:[26]

- The Kelsey-Seybold Family Medicine Residency Program – considered a model for training new physicians in a team-based, multispecialty environment – announced its closure due to financial instability in 2009;

- The Texas Tech University Rural Program in Abilene closed its doors for financial reasons in 2008; and

- The Christus St. Elizabeth Family Medicine Residency Program in Beaumont was forced to close in 2002 due to a lack of financial support. Of the 74 graduates from the program practicing medicine in 2005, 88 percent practiced in health professional shortage areas.

According to a recent report from the Department of State Health Services, Texas will need approximately 3,400 more primary care physicians than it is on track to produce by 2030 to meet demand. Despite this, the 2021 state budget cuts the Family Practice Residency Program from $5 million a year to $4.75 million and reduces funding for family medicine residents from $14,300 per resident in 2011 to just $5,400 in 2021.[27]

Considering the fact that it costs the state approximately $168,000 to produce one medical school graduate, and in 2016 (the most recent year for which data was available) it produced 180 more graduates than it had first-year residency slots – representing a lost investment of $30 million in that one year alone – any cost savings to the state by reducing funding for residency programs that have been proven effective in producing Texas-based primary care physicians is

[24] https://www.highered.texas.gov/institutional-resources-programs/institutional-grant-opportunities/family-medicine-residency-program/
[25] https://www.aamc.org/data-reports/students-residents/interactive-data/table-c6-physician-retention-state-residency-training-state
[26] https://www.tafp.org/Media/Default/Downloads/advocacy/Support_PC_residencies.pdf
[27] https://www.tafp.org/news/tfp/q1-2021/lege-update

far outweighed by the financial loss that it incurs when physicians leave the state to train (and frequently remain) elsewhere.[28]

It is important to note that the osteopathic profession has a longstanding commitment to providing care in rural and underserved areas, and many of the beneficiaries of the abovementioned programs are DOs. According to the 2019 Osteopathic Medical Profession Report, 57% of DOs currently practice in primary care specialties, surpassing the percentage of MDs entering primary care, which has been on the decline since 2011.[29] Many osteopathic medical schools are located in rural and underserved areas, and nine out of the top ten medical schools with the most graduates practicing primary care are osteopathic schools.[30] Further, in 2020, the Oklahoma State University College of Osteopathic Medicine at the Cherokee Nation became the first tribally-affiliated college of medicine in the United States.[31]

Driving Specialty Decisions at the Undergraduate Medical Education Level

The experiences of students during their first four years of medical education are critical in shaping professional interests. An analysis of the last 10 years of data from the American Association of Colleges of Osteopathic Medicine's (AACOM) graduate survey found that mentoring by faculty may have an outsized influence in decision making on future specialty and practice setting. In 2019, students who indicated that they intended to practice in primary care or in a rural setting also tended to be more satisfied with their faculty mentoring during the undergraduate medical career.[32] A similar survey by the Association of American Medical Colleges had similar findings, where 52.1 percent of respondents cited "role model influence" as having a strong influence on their specialty choice in 2020. The June 2019 report by MedPAC evaluated the current pipeline of primary care physicians, and it came to similar conclusions regarding the influence of the undergraduate medical education experience on practice decisions.[33]

This evidence suggests that specialty decisions are made well before graduation from medical school. Building training programs where students gain exposure to high-quality mentors in primary care, and even engage in community-oriented primary care education may ultimately make students more likely to go into a primary care specialty or practice in underserved settings.[34] Several Health Resources and Services Administration (HRSA) programs seek to strengthen primary care training and steer students at the undergraduate medical education

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[28] https://www.tafp.org/Media/Default/Downloads/advocacy/Support_PC_residencies.pdf

[29] Knight, Victoria. "American Medical Students Less Likely To Choose To Become Primary Care Doctors." *Kaiser Health News*, July 3, 2019. https://khn.org/news/american-medical-students-less-likely-to-choose-to-become-primary-care-doctors/.

[30] No Author. "DO Schools Lead in Primary Care, Rural Care and Caring for Underserved in U.S. News' Medical Schools Ranking." American Osteopathic Association, April 2, 2021. https://osteopathic.org/2021/04/02/do-schools-lead-in-primary-care-rural-care-and-caring-for-underserved-in-us-news-best-medical-schools-ranking/.

[31] https://medicine.okstate.edu/hastings/index.html.

[32] American Association of Colleges of Osteopathic Medicine. "Osteopathic Medical School Graduates: Evaluation of Faculty Mentoring". 2020.

[33] "Issues in Medicare beneficiaries' access to primary care". Medicare Payment Advisory Commission Report to Congress. June 2019. http://www.medpac.gov/docs/default-source/reports/jun19_ch5_medpac_reporttocongress_sec.pdf?sfvrsn=0

[34] Magzoub, Mohi Eldin M. A. MD, PhD; Schmidt, Henk G. PhD A Taxonomy of Community-based Medical Education, Academic Medicine: July 2000 - Volume 75 - Issue 7 - p 699-707

level. Expanding these programs can be a useful tool in expanding the primary workforce in underserved communities.

HRSA's 2020 report to the HHS Secretary states that expanding the availability of longitudinal training programs, instead of 4-8 week rotations, provide meaningful education in health promotion, disease prevention, and care management for the chronically ill, while also making students more likely to ultimately specialize in primary care.[35] [36] While HRSA has some grant programs that can help institutions develop innovative undergraduate medical education programs to address workforce shortages, much of HRSA's work focuses on graduate medical education. A grant program for innovation in primary care and development of longitudinal programs could help expand the pipeline of students who choose primary care upon graduation.

Data from HRSA also suggests that there is strong demand for primary care training, and additional funding for students could support more students in pursuing a medical education that emphasizes this type of practice. The National Health Service Corps (NHSC) is one program that supports students who choose to pursue a medical education and practice in primary care. The NHSC scholarship program has been highly successful, but it can only support a limited number of applicants. In 2019, the program saw nearly 1,900 applicants, but only 200 new awards were granted. Identifying more students who are interested in primary care early in their careers, encouraging commitment, and providing financial support for their education in this specialty can help produce more providers who are ready to meet the needs of rural and underserved communities across the country.

Enhancing Payment for Medicaid

Medicaid enrollees comprise a significant share of primary care visits and ensuring that physician practices that serve Medicaid populations receive payment at level that is needed to remain viable is critical to promoting access in rural and underserved communities. On average, state Medicaid programs pay for healthcare services at 72 percent of the Medicare rate; for primary care services, that number drops to 66 percent.[37]

Increasing Medicaid payment to at least an equal level with Medicare will allow more physicians to accept Medicaid patients and attract them to practice in high-need settings. An analysis by Health Affairs describes how physicians cite low reimbursement rates as a deterrent to participation. Additionally, a MACPAC and University of Minnesota analysis of National Ambulatory Medical Care Survey data found that the proportion of physicians accepting new patients varies significantly based on patient coverage type. Providers were less likely to accept new patients with Medicaid, with 70.8 percent accepting new patients, than with Medicare (85.3 percent) or private insurance (90.0 percent). MACPAC also found in their analysis that state Medicaid reimbursement was correlated with new patient acceptance. Every 1 percentage point

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[35] Pfarrwaller E, Sommer J, Chung C, Maisonneuve H, Nendaz M, Junod Perron N, Haller DM. Impact of Interventions to Increase the Proportion of Medical Students Choosing a Primary Care Career: A Systematic Review. J Gen Intern Med. 2015 Sep;30(9):1349-58. doi: 10.1007/s11606-015-3372-9. PMID: 26173529; PMCID: PMC4539313.

[36] "Seventeenth Annual Report to the Secretary of the United States Department of Health and Human Services and the Congress of the United States". Health Resources and Services Administration. October 2020.

[37] Zuckerman, Skopec, and Epstein. "Medicaid Physician Fees after the ACA Primary Care Fee Bump." Urban Institute, March 2017. https://www.urban.org/sites/default/files/publication/88836/2001180-medicaid-physician-fees-after-the-aca-primary-care-fee-bump_0.pdf

increase in the Medicaid-to-Medicare fee ratio appears to increase acceptance by 0.78 percentage points.[38]

Other studies have confirmed the MACPAC finding. A recent study by the Federal Reserve Bank of Chicago analyzed the impact of the Medicaid primary care rate increase that was implemented by the ACA and expired in 2015. The study found that the increase in Medicaid payments was associated with improvements in access and health measures among Medicaid beneficiaries. The study also found a correlation between Medicaid rates and usage of health care services by beneficiaries. The researchers identified that a $10 increase in physician reimbursement is associated with a 0.29 percentage point (1.5 percent) increase in the probability that respondents covered by Medicaid went to a doctor's office in the preceding two weeks.[39] This is likely because increased availability of providers and appointment times supports patient engagement in their own care, as well as longitudinal relationships between patients and providers.

Federal policies should ensure that Medicare payment rates serve as a floor for Medicaid rates. Improving Medicaid rates will help primary care practices afford to practice in settings with a larger share of Medicaid patients.

Conclusion

Effectively leveraging a physician-led, team-based model of care delivery is critical to meeting our nation's growing health care needs moving forward. Although the investment required of state and federal governments in order to adequately address these issues is significant, as the research above demonstrates, effectively training physicians in areas of high need and utilizing the physician-led team model will help us achieve cost-effective solutions without sacrificing quality of care.

Physicians remain the only category of health care professional to complete comprehensive medical education, training and competency demonstration requirements that is designed to ensure the highest, uniform standards of care nationwide. While other provider types have sought to increase their education and training in recent years, the fact remains that there is a lack of consistency, uniformity and information about the long-term outcomes of these providers, who largely resist physician involvement while continuing to seek equivalent rights and reimbursement once they achieve independent practice, which defeats the stated goals of legislatures in granting them such rights.

All patients deserve to be treated by fully trained and licensed medical professionals, regardless of location or ability to pay, and the physician-led, team-based model of care ensures that fully licensed physicians are appropriately involved in patient care while valuing the unique training and skill sets of all health care providers.

Source: H343-A/21

Status: 2021

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[38] Holgash and Heberlein. "Physician Acceptance of New Medicaid Patients". Medicaid and CHIP Payment and Access Commission. January 2019. Presentation. https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf

[39] Alexander and Schnell. "Closing the Gap: The Impact of the Medicaid Primary Care Rate Increase on Access and Health"

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White Paper – Reforming the Health IT Landscape to Improve the Patient and Clinician Experience

Policy Statement

The American Osteopathic Association adopted the white paper, Reforming the Health IT Landscape to Improve the Patient and Clinician Experience as its position on policies to empower consumers with their personal health data while ensuring that information is seamlessly provided to physicians at the point of care.

Reforming the Health IT Landscape to Improve the Patient and Clinician Experience

Overview

This paper addresses the evolution of health information technology (HIT), recent HIT efforts and shortcomings, opportunities to improve HIT infrastructure to support patient care and clinicians and identifies potential solutions.

Introduction

Information technology in the healthcare industry has steadily advanced over the past two decades. Much of this growth can be attributed to the widespread adoption and meaningful use of electronic medical records (EHRs). However, adoption and utilization of EHRs has not been easy for physician practices or free from burden.

As the use of EHRs has increased, recent legislative activities have shifted to address longstanding barriers to interoperability and electronic exchange of healthcare information. This paper discusses the evolution of health information technology (HIT) and describes specific policy solutions to enhance interoperability of healthcare data, improve accuracy, increase efficiency, and reduce administrative burden.

The Evolution of Health Information Technology

The first major incentive for HIT started with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) when the federal government mandated that health plans, healthcare clearinghouses, and certain healthcare providers comply with technical data requirements for electronic transactions. HIPAA established standards for electronic exchange of data; code set standards for diagnosis, procedures and diagnostic tests; unique identifiers for employers, providers and health plans; standards for storage of data at medical facilities, health insurance companies, and billing clearinghouses; and privacy standards to protect sensitive patient health information (PHI) from being disclosed without the patient's consent or knowledge.

In 2001, the Administrative Simplification Compliance Act required that all initial Medicare claims be submitted electronically, except in limited situations. However, it was the HIPAA provisions for simplifying administration of health insurance that encouraged the healthcare industry to computerize patients´ medical records. This specific part of the Act spawned the Health Information Technology for Economic and Clinical Health Act (HITECH).

The use of the EHR has been a consistent topic of frustration and burnout for physicians across the U.S. healthcare system. When the HITECH Act passed in 2009, its purpose was to make health data storage, sharing, and reporting more seamless and efficient, easing provider workloads, enhancing the patient experience, and improving care quality.

In 2011, the meaningful use (MU) component of HITECH was implemented to expand the adoption of HIT and facilitate the use of EHRs. The HITECH Act authorized the Centers for Medicare & Medicaid Services (CMS) to establish the Medicare and Medicaid EHR Incentive Programs. These programs paid approximately $35 billion in incentive payments to eligible professionals, hospitals, and critical access hospitals to adopt, implement, upgrade, and demonstrate the use of certified EHR technology (CEHRT).i The reporting requirements involve the ability of an EHR to perform such functions as generating problem lists, exchanging patient clinical data, or e-prescribing.3 The MU program launched in three stages beginning in 2011. The focus of Stage 1 was data capture and sharing. In 2014, the Office of the National Coordinator for Health IT (ONC) created Stage 2, which sought to extend the requirements of Stage 1 and promote more advanced clinical processes. Stage 3 focused on improving overall outcomes. The combination of incentive payments for participation, paired with a penalty for failing to meet meaningful use criteria using the ONC certified technology, resulted in significantly expanded use of EHRs.

To qualify for federal funds, eligible healthcare professionals and hospitals not only had to adopt EHRs but also demonstrate meaningful use of CEHRT by achieving minimum core objectives in each stage of the MU program. It was also necessary to demonstrate compliance with the HIPAA security and privacy rules by conducting risk assessments. Even with the financial incentives, the requirements of the MU program were overly burdensome for physician practices and failure to meet them resulted in reduction of Medicare and Medicaid payments. While interoperability was one of the goals for the MU program, it failed in that regard. However, the financial incentive to adopt EHRs gave birth to an industry whose technology was not quite ready for its intended purpose, which is evident by the lack of uptake in the free market.

In 2016, MU was wrapped into the Merit-Based Incentive Payment System (MIPS) established under the Medicare Access and CHIP Reauthorization Act (MACRA). In 2018, CMS renamed the Medicare and Medicaid EHR Incentive Programs to the Promoting Interoperability Programs to better align with MACRA provisions for electronic exchange of healthcare information.

MACRA sought to promote “widespread interoperability” which it defined as “the ability of two or more health information systems or components to exchange clinical and other information and use the information that has been exchanged by means of common standards to provide access to longitudinal information for health care providers to facilitate coordinated care and improve patient outcomes.”[ii]

In 2009, only 12.2 percent of hospitals had adopted a basic EHR system. By 2017, the number of hospitals with an ONC certified EHR systems increased to 96 percent of hospitals[iii] and 80 percent of office-based physiciansiv. Despite this rapid adoption of EHR technology, the vision of the HITECH Act and MACRA, an interoperable health data ecosystem that promoted efficiency and value in the healthcare system, was far from realized.

Data systems across the country became fragmented and were not interoperable. This was partially due to misaligned incentives in the HITECH Act that were heavily focused on provider requirements, with emphasis on adoption of an EHR with basic capabilities. As the program progressed, incentives were not shifted towards information exchange until MACRA, at which

point a highly siloed health data environment had formed. In 2016, a survey of healthcare providers found that “only 6% of healthcare providers report that information accessed from exchange partners on a different EMR is delivered in an effective way that facilitates improvement to patient care.” Additionally, platforms often were not designed in a usable manner, with only 8 percent of providers reporting that data could be received and located within the workflow.v The lack of efficient technology manifests in high rates of burnout and time taken away from patients. An observational study of physician practices found that physicians spend 27 percent of their time with patients and 49.2 percent of their time on EHR and desk work. While in the examination room with patients, physicians spent approximately 53 percent of the time face-to-face with patients and 37 percent on the EHR.[vi]

Recent HIT Efforts and Shortcomings

Congress addressed the fragmentation of data and lack of exchange in our healthcare system in the 21st Century Cures Act (Cures Act). Like MACRA, it mandated support for interoperable network exchange to be spearheaded by the ONC in collaboration with the National Institute of Standards and Technology and other divisions of HHS. ONC engaged in rulemaking in 2018 and 2019 to implement the interoperability and information blocking provisions of the Cures Act. This was done in tandem with the CMS Interoperability and Patient Access final rule, which developed new HIT compliance requirements for providers and certain payers to improve the electronic exchange of healthcare data and enable patients to safely and securely access their medical information through a third-party application of their choice.

The ONC rule made sweeping changes to HIT regulation to promote data sharing, empower consumers by granting them greater control over their data, and prevent healthcare entities from blocking the sharing of health data. The rule established a standard for the development of application programming interfaces (APIs), required EHR developers publish their APIs to ensure that different softwares and networks are able to effectively exchange information, and updated EHR certification criteria with a focus on interoperability. The update involves replacing the Common Clinical Data Sets required for certification with the new United States Core Data for Interoperability (USCDI).

The new data requirements are more extensive and will promote patient matching, tracking origins of data, and supports the sharing of clinical notes. Ultimately, USCDI establishes standards and formats for data to allow more seamless sharing. The rule also defines what entities are covered by information blocking, defines what constitutes information blocking, and outlines exceptions. The information blocking provisions of ONC’s Cures Act final rule took effect on April 5th, 2021, with various compliance dates staggered through 2023.[vii]

These recent actions have helped level the playing field and create a regulatory framework that enables true interoperability across the U.S. healthcare ecosystem. However, much work needs to be done to ensure that the promise of true interoperability is realized, and that seamless health information exchange can be used to support population health and enhance the patient and clinician experiences.

Opportunities to Improve HIT Infrastructure to Support Patient Care and Clinicians

The next step in this process is to ensure that information is readily available to physicians and other clinicians at the point of care to improve the quality and efficiency of care, and to ensure that the health IT infrastructure is improved to better serve communities that are often left

behind in our health care system. Areas that critically need to be addressed to achieve these goals include the following:

Effective matching of patient data

Patient identification (patient matching) remains a persistent problem in ensuring that electronic health record (EHR) data is complete and accurate. Errors and missing information remain common in the electronic health record ecosystem, with several studies indicating that between 8 to 22 percent of all records are split or duplicate.viii ix These high-duplication and mismatched rates often translate into unnecessary resource use and poor outcomes when patient records are not up-to-date or contain inaccurate information. A 2016 report indicated that 4 percent of duplicate records result in negative clinical care and outcomes.x Split and mismatched records make it difficult for physicians to have the full picture of a patient's health and care received, and it also makes it more difficult for the patient to have access to their full record.

Access to Data at the Point of Care

Access to a patient's complete medical history, including procedures, chronic conditions, and medication history, is critical to delivering high quality care. However, patients frequently misreport and or provide incomplete histories, which can result in negative outcomes due to harmful drug interactions or procedures conducted without knowledge of another comorbid condition. A study of 2,063 patients whose histories were collected during emergency department (ED) triage found that of all patients identified as taking medications, 48 percent failed to identify at least one of their medications, with a median of two drugs missed. Of the drugs missed at triage, 73 percent were prescription medications.xi Patients will often omit parts of their medical history for various reasons: focusing only on information the patient believes to be important, forgetting of information due to complex histories or medication lists, or intentional omission. While improved interviewing can improve this issue, access to comprehensive records at the point of care is the optimal and most efficient way to obtain a complete picture of a patient's health. Enhanced sharing of patient data can also be used to create analytics tools built into EHR workflows.

Streamlining Prior Authorization Processes to Eliminate Care Delays

Prior authorization is a cumbersome process that requires physicians to obtain pre-approval for diagnostic procedures and medical treatments before they can render care to their patients. While the process is often conducted electronically, prior authorization sometimes needs to be obtained over the phone or via fax. Even when obtained electronically, payors have different processes, policies, and electronic platforms. The process for obtaining this approval is costly. The Council for Affordable Quality Healthcare (CAQH) estimated that the financial impact of prior authorization requirements to providers in 2019 was approximately $528 million, and the average transaction takes 21 minutes of provider staff time.xii If the healthcare industry were to fully shift to electronic prior authorizations with consistent technical standards that allow submissions from a single platform, providers could save 17 minutes per transaction and $355 million per year. However, for providers who do submit electronic prior authorizations, the process is still partially manual, as they need to log into separate portals for each payor and complete varying documentation requirements. Because prior authorization platforms do not integrate with the provider's EHR system, the process generates significant barriers to the efficient care of patients. The current method for prior authorization is costly for providers, detracts from time spent with patients, and often forces patients to go without care or delays care. This can lead to needless increased suffering for the patient and worsening of their

condition, ultimately leading to increased cost of care. In order to have a truly effective prior authorization process, fully integrated electronic universal standards must be incorporated by all payers.

Enhancing Health IT Regulatory Frameworks to Address Social Determinants of Health

A quickly growing body of research indicates that social determinants of health may have a greater impact on a patient's overall health and outcomes than treatment they receive. The HHS Healthy People 2030 initiative defines social determinants of health as the "conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." It groups these factors into five domains, which include economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.[xiii] A recent article published in Health Affairs compiles various studies that estimate the relative impact of various health determinants on outcomes.[xiv] A study published by the University of Wisconsin-Madison found that behaviors contribute to 30 percent of outcomes, social circumstances contribute to 40 percent, environment contributes to 10 percent, and medical care contributes to 20 percent of outcomes. Overall, other studies have come to similar conclusions that 80 percent of the contributors to health outcomes are social determinants of health.[xv]

The COVID-19 pandemic particularly highlighted the impact of social determinants on outcomes and how social factors can drive disparities. Over the course of the pandemic, data has demonstrated that housing status, socioeconomic factors, and behaviors such as smoking were significant determinants of whether an individual contracted COVID-19 and the severity of their case. A study published in 2020 highlights how beyond infection, there are other downstream consequences from the pandemic. For example, children who depend on school lunches may face nutrition issues due to school closures.[xvi] During the pandemic, the U.S. also saw unprecedented use of telehealth to expand access to health services and improve care. However, there are clear gaps in health IT infrastructure that prevent social determinants from being recorded and addressed.

The U.S. health system, and healthcare infrastructure, are not historically well equipped for coordinating care or capturing data outside the clinical setting. While ICD-10 codes exist for capturing information about social determinants of health in health records, many providers are not well educated on how to use them. Additionally, these codes often lack precision. At the same time, a regulatory framework for sharing health information and coordinating care with community-based organizations is relatively weak. These organizations often use different information management tools than health providers, and standards do not exist for data exchange. Even amongst certified health IT products, ONC does not have a required technical standard for sharing information related to social determinants of health. These challenges not only prevent sharing of individual level data for informed clinical decision making, but also stifle the aggregation of patient data to better understand the impact of social determinants.[xvii]

Capturing and sharing social determinants of health information is critical to improving care coordination and management both within and outside of a clinic's four walls. However, the task of capturing this data should not fall solely on physicians. Ultimately, to build a health care system that is equipped to address social determinants of health, and to build an infrastructure for value-based care systems, changes to current HIT infrastructure are critical.

Appropriate Use of Data by Third-Party Apps and Patient Protections

Patient engagement in their own care and health maintenance is critical to overall well-being and promoting better outcomes. Patient health applications provide not only an opportunity for patient engagement in their own care, but they can also empower patients to share data with physicians and provide a clearer picture of their medical history. This is the goal of the CMS Interoperability and Patient Access final rule. However, third party apps are not properly regulated, and health data, which comprises some of the most sensitive information about an individual, can be compromised and exploited when downloaded onto third-party platforms. When patients want to use a health management application, they are often required to agree to user "terms and conditions" which often contain language permitting the developer to pass along user information to third parties. A recent study examining the 24 top-rated Android apps for health medicine management found that 19 of the 24 apps shared user data with third parties. Of these apps that shared data, 66 percent of the third parties that these apps shared data with "provided services related to the collection and analysis of user data, including analytics or advertising, suggesting heightened privacy risks."[xviii]

Solutions

Effective Matching of Patient Data

ONC should create technical standards and best practices governing how patients can monitor, update, or verify their information through applications and portals. The ONC's final rule on interoperability gives patients unprecedented ownership over their own data, and this creates an opportunity to allow them to review demographic information that can impact the movement and matching of their record across platforms. Additionally, minor changes to data standards will help facilitate exchange of certain patient information. ONC should also standardize address formats within the USCDI and add a standard for gender identity.

Access to Data at the Point of Care

The CMS Interoperability and Patient Access rule finalized in 2020 requires Medicare Advantage plans, Medicaid and Children's Health Insurance Program (CHIP) managed care plans, state agencies and Qualified Health Plans on federally facilitated exchanges to enable payor-patient exchange of claims data via FHIR API. This capability should be expanded to enable a payor-provider claims data exchange via FHIR API, and this should also apply to ACA qualified plans and Employee Retirement Income Security Act (ERISA) plans. The API should be similar to CMS' Data at the Point of Care pilot enabled by the Blue Button 2.0 initiative. The pilot program has sought to give providers insight into patients' claims and medication histories within their EHR workflow so they could make more informed clinical decisions during a patient encounter. A change of this nature would require legislative action to grant federal agencies authority to regulate this information sharing and qualify non-compliance as a form of information blocking. Additionally, having data on cost and coverage can prevent loss to follow-up care, particularly for patients where out-of-pocket cost is likely to result in deferred care, and also reduce administrative burden associated with prior authorization.

Streamlining Prior Authorization Processes to Eliminate Care Delays

Because of the growing burden created by prior authorization processes, some congressional and regulatory action has been taken to begin to address the issue. Most recently, CMS issued transaction standard for electronic prior authorization (ePA) under the Part D e-prescribing program. These ePA transaction standards would allow prescribers to use an electronic prescribing (eRX) system or an EHR with an eRX system to determine whether a patient's Part

D plan requires prior authorization for a given medication and to receive responses in real time.xix While this regulation had many positive aspects, overall, given the limited scope of the part D program, it did little to address the larger issues of standardizing prior authorization across the healthcare system. Congress has also made a legitimate effort to respond to this issue and develop policy to standardize electronic prior authorization. However, nothing has passed into law at the time of this publication, and active legislation during the 117th Congress is limited in scope to just Medicare Advantage (MA) plans.[xx]

To achieve fully standardize electronic prior authorization that integrates into a provider's workflow, legislation must be enacted that establishes technical requirements for private insurance plans regulated under the ACA and ERISA, as well as all CMS contractors that administer MA plans. This legislation must establish a universal electronic prior authorization (ePA) program and require all healthcare plans to adopt ePA capabilities that follow a single technical specification that allows payor platforms to seamlessly connect to other certified health IT. As is current practice, prior authorizations should still be reviewed by qualified medical professionals, and finally, there should be a streamlined process for reviewing prior authorization policies on routinely approved items and services. These changes are critical to ensuring that a provider's workflow is efficient, and that patient care is not delayed or impeded, resulting in worse outcomes.

Enhancing Health IT Regulatory Frameworks to Address Social Determinants of Health

In order to ensure that health IT can be leveraged to address social determinants of health, several changes to the current environment are needed. These changes would address the issues of data capture, interoperability and exchange, value-based care and payment.

To address improved data capture, three key changes will help ensure that health records contain more robust information on social determinants. First, ICD codes need to be made more granular to ensure appropriate information capture, and providers need to be educated on how to use relevant codes. Additionally, universal reimbursement standards should be developed to ensure consistent coding and appropriate payment for screening for social determinants and linkage to appropriate services. To address interoperability and exchange, ONC should add a data class to the USCDI to ensure that data relating to social determinants of health can be captured and shared in certified health IT. Health Level Seven (HL7) launched an initiative called the Gravity Project to create national standards for representing social determinant data in health IT. In October 2020, the Gravity Project submitted two approaches to ONC for adding a new data class for social determinants of health.xxi Testing and adopting these standards will help ensure improved information sharing. In addition to the new USCDI data class, the AOA encouraged ONC to develop a pilot project to identify how to help community-based organizations better integrate their data systems with certified health IT.

Once health IT infrastructure is strengthened, HHS, plans, and providers can leverage newly available data to drive development of value-based initiatives. Because factors beyond the care rendered by a physician have such significant influence on a patient's outcomes, it is critical that efforts to address social determinants are incorporated into value-based initiatives. Several efforts to achieve this are ongoing. An analysis by one managed care organization found that its efforts to meet patients' needs for social services by referring them to resources for transportation, food programs, financial assistance for utilities, education programs, and housing services helped reduce health expenditures by as much as 10 percent for patients who had social needs met.xxii However, action by providers at the point of care can have a greater

impact, and models should be designed that incentivize and reward providers who help identify and address patients' social needs.

Appropriate Use of Data by Third-Party Apps and Patient Protection

In 2021, the comment period closed on a proposed rule by the HHS Office for Civil Rights (OCR) to modify HIPAA. The rule fell short in advancing the security of sensitive patient data as it relates to third party apps. While the rule adds a definition for a "patient health application", it does not consider these applications covered entities. Since the user of a third-party application agrees to the "terms and conditions", and the applications are not covered entities, individually identifiable consumer health information collected by the apps or on personal health trackers often does not have to be stored and used in compliance with HIPAA requirements for protected health information (PHI). As such, third-party apps are allowed to transfer, sell, or share patient's data without informing the consumer to obtain consent.

OCR should recognize applications on which patients can download PHI as a covered entity or require them to develop business associate agreements with vendors from whom they download data. Alternatively, if these approaches are not feasible, OCR should create a new class of entity that is subject to HIPAA privacy rules that captures these applications. HHS should also develop standards for authenticating patient identities to ensure that the third-party apps are held to similar standards as patient portals of HIT vendors.

While most of these solutions may be able to be address through the rule making process, some reforms will have to be codified through new federal legislation. In light of this, legislation which prevents data mining, sharing, or selling of personal health data by third-party apps must be passed into law.

There has been a willingness to work on this issue in Congress, in particular in the Senate Committee on Health, Education, Labor and Pensions (HELP), which has discussed this during public hearings, and with the introduction of legislation which seeks to address these gaps. Healthcare stakeholders must advocate for the passage of legislation which guarantees that no third-party entities are not allowed to transfer, sell or share any individually identifiable consumer health information collected regardless of the modality used to collect such data so that patients may continue to be an active participant in their own healthcare and be protected under the law without fear of losing their privacy by their use of third-party apps.

Conclusion

Throughout its history, HIT and EHR data entry has been a consistent topic of administrative burden and burnout for physicians across the U.S. Even when the government provided monetary incentives, it had become abundantly clear that reaching the goal of a fully interoperable EHR ecosystem that aids physician clinical decision making and lowers cost while improving quality of care is easier said than done. While the topics outlined in this document are by no means a fully comprehensive list of every concept or solution needed to fix the HIT ecosystem, it is clear that to fully realize the benefits of digital health information, we must first have truly meaningful data.

As outlined above, this includes, but is not limited to, the implementation of legislative and regulatory policies which empower consumers with their personal health data while ensuring that information is seamlessly provided to physicians at the point of care. However, to have the greatest impact, we must go beyond just access to medical data for physicians. In this new

digital world, we must also provide appropriate patient protections for any data which is acquired and used by any third-party apps. Finally, we must support and help implement future policies that improve community well-being by enhancing the HIT regulatory frameworks that influence non-medical social determinants of health factors that affect health outcomes. While much of the legislative and regulatory work is slow and tedious, if implemented correctly, effective EHR data has the possibility to improve quality of care while lowering costs, ultimately resulting in promoting healthy communities across the United States.

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Source: H344-A/21

Status: 2021

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Defining New Physicians in Practice

Policy Statement

The American Osteopathic Association defines a new physician in practice as a physician who is no more than 5 years past the completion of postdoctoral training.

Source: H300-A/22

Status: 2017; 2022 Reaffirmed

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State Licensure of Managed Care Organizations (MCO) Medical Directors

Policy Statement

The American Osteopathic Association supports legislation or regulations that would require all Managed Care Organization (MCO) medical directors to be fully licensed physicians of the state where the care is being provided; and supports state medical boards' rights to oversee and discipline any medical director of an MCO licensed as a physician in their state.

Source: H301-A/22

Status: 1999; 2004 Reaffirmed; 2009 Reaffirmed; 2017 Reaffirmed; 2022 Reaffirmed

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Administrative Rule-Making Process

Policy Statement

The American Osteopathic Association supports closer federal and state legislative scrutiny of the administrative rule-making process effectively monitor the development of regulations and assure their conformity with expressed legislative intent.

Source: H302-A/22

Status: 1986; 1992 Reaffirmed as Amended; 1997 Reaffirmed; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed; 2022 Reaffirmed

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Advance Directives

Policy Statement

The American Osteopathic Association supports advance directives and will proactively assist in introducing this concept into federal legislation.

Source: H303-A/22

Status: 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed; 2022 Reaffirmed

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Interstate Prescription Drug Monitoring Program (PDMP)

Policy Statement

The American Osteopathic Association supports an Interstate Prescription Drug Monitoring Program (PDMP) that allows prescribers, dispensers, or their designated staff in any state to access a patient's relevant prescription history, regardless of their residing state at no cost to the prescriber or dispenser.

Source: H304-A/22

Status: 2017; 2022 Reaffirmed as Amended

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Improve Life-Saving Access to Epinephrine

Policy Statement

The American Osteopathic Association will advocate for states to enact comprehensive epinephrine training protocols for use during an allergic reaction for medical and non-medical professionals working in public facilities and supports increased availability of epinephrine in all forms to properly trained individuals.

Source: H305-A/22

Status: 2017; 2022 Reaffirmed as Amended

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Prescription Drugs

Policy Statement

The American Osteopathic Association will: urge the FDA to strengthen its inspection and approval procedures and equivalency standards to ensure that generic drugs approved by the FDA are therapeutically equivalent to the brand drug for which they are to be substituted; oppose mandatory use of generic drugs or generic substitution programs that remove control of the treatment program from the physician; urge the development and enactment of public policy that would mandate that prescription drug plans cover name-brand medications when evidence-based treatment protocols recommend their use; act to educate healthcare insurers and managed care companies on the potential dangers of formulary substitutions; support public policy that requires a physician be available for consultation in a timely manner on pharmaceutical formulary and drug substitution decisions; oppose any attempt by federal or state governments to restrict, prohibit, or otherwise impede the prerogative of physicians to prescribe and dispense appropriate medications to their patients; urge the FDA to ensure safe and consistent drug supply that avoids shortages and ensures adequate generic pharmaceutical manufacture and supply for U.S. patients and physicians.

Source: H307-A/22

Status: 1990; 1995 Reaffirmed, 1997; 2002 Reaffirmed as Amended; 2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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Federally Funded Health Centers

Policy Statement

The American Osteopathic Association supports adequate staffing for the physicians providing medical care in federally funded health centers and opposes having a nurse practitioner or physician assistant in lieu of physicians in federally funded health centers. The AOA continues to support physician-led team healthcare delivery in all federally funded health care centers.

Source: H308-A/22

Status: 2002; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed as Amended; 2022 Reaffirmed as Amended

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Disparities Between Rural and Urban Practices

Policy Statement

The American Osteopathic Association supports federal legislation that would sustain a minimum geographic cost-of-practice index value for physicians' services at or above 1.000.

Source: H309-A/22

Status: 2002; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed; 2022 Reaffirmed

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Preservation of Antibiotics for Medical Treatment

Policy Statement

The American Osteopathic Association supports legislation or regulatory efforts that would ban feed additive uses of antibiotics for non-therapeutic uses in animals such as for growth promotion, feed efficiency, weight gain, routine disease prevention or other routine purposes.

Source: H310-A/22

Status: 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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Guidelines for Nutritional and Dietary Supplements

Policy Statement

The American Osteopathic Association requests: the Food and Drug Administration (FDA) to be diligent in their monitoring of all products marketed for human consumption, including nutritional supplements, and that there be close attention to reported adverse events directly caused by any of these products; and that the US Congress pass legislation requiring dietary supplements to undergo pre-market safety and efficacy evaluation by the FDA.

Source: H311-A/22

Status: 2002; 2007 Amended; 2011 Reaffirmed as Amended; 2012; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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Sexual Harassment

Policy Statement

The American Osteopathic Association supports state and federal legislation that prohibits sexual harassment.

Source: H312-A/22

Status: 1992; 1997 Reaffirmed, 2002 Reaffirmed as Amended; 2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed; 2022 Reaffirmed as Amended

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Due Process in Agency Determinations

Policy Statement

The American Osteopathic Association opposes any and all existing or proposed federal and state rules or procedures, and their underlying laws where no provision is made for a prior, fair, and formal hearing.

Source: H313-A/22

Status: 1982; 1987 Reaffirmed as Amended; 1992 Reaffirmed, 1997 Reaffirmed, 2002 Reaffirmed; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed; 2022 Reaffirmed as Amended

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Regulation of Health Care

Policy Statement

The American Osteopathic Association supports regulation in health care as follows:

1.The need for any new regulation must demonstrate that access to care, or patient safety, or the quality of health care provided, will be improved by the proposed regulatory action and that the claimed improvement can be accomplished at an acceptable cost to the public.

2. In all matters where the health profession has demonstrated its capacity for quality self-regulation, government at all levels should not impose additional or preemptive regulation.

3. Where the need for regulation has been demonstrated, it should emanate from the lowest applicable level of government.

4. Where there is a demonstrated necessity for regulation of health care, such regulation must be drawn and implemented in such a way as to promote pluralism and preserve the free enterprise system in health care.

5. Every effort should be made when formulating new regulations to harmonize them with existing regulations to prevent increasing existing regulatory burden.

Source: H315 – A/22

Status: 1997 Reaffirmed; 2002 Reaffirmed as Amended; 2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed; 2022 Reaffirmed as Amended

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Occupational Safety and Health Administration (OSHA) Regulations

Policy Statement

The American Osteopathic Association urges that the Occupational Safety and Health Administration (OSHA) prioritize education and training to create a safe workplace before considering assessment of fines.

Source: H316 – A/22

Status: 1992; 1997 Reaffirmed as Amended, 2002; 2007; 2012 Reaffirmed; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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Patient Safety

Policy Statement

The American Osteopathic Association endorses patient safety in health care that encourages payers to provide adequate payment so that physicians and hospitals can provide safe quality care.

Source: H317 – A/22

Status: 2002; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed; 2022 Reaffirmed as Amended

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Promotion of School Based Health Education

Policy Statement

The American Osteopathic Association will continue to urge the state legislatures to enact measures establishing programs that follow the Centers for Disease Control and Prevention's Whole School Whole Community, Whole Child (WSCC) model.

Source: H318 – A/22

Status: 1992; 1997 Reaffirmed, 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed; 2022 Reaffirmed as Amended

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Recoupment Laws

Policy Statement

The American Osteopathic Association supports public policy which subjects all parties to the same terms and time frame for billing, payment and appeal.

Source: H319 – A/22

Status: 2002; 2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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Right to Practice and Payment for Osteopathic Manipulative Treatment

Policy Statement

The American Osteopathic Association will pursue any and all legal and legislative recourse to protect patient access and the rights of its member physicians to deliver approved and beneficial modalities of healthcare; will work with legislators and state licensing boards to preserve the osteopathic profession's right to establish and maintain standards of practice of osteopathic manipulative treatment; objects to any attempt by third party payers to deny or restrict payment for osteopathic manipulative treatment when appropriately rendered by a physician with appropriate training in osteopathic principles and practice; and will continue to oppose any attempt by third-party payers to interchange and/or combine osteopathic manipulative treatment codes with codes used to describe other forms of manual therapy.

Source: H320 – A/22

Status: 1986; 1991 Reaffirmed as Amended, 1992, 1997, 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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Equity in Medicare & Medicaid Payments

Policy Statement

The American Osteopathic Association will actively support federal legislation, rules or regulations, to include socioeconomic risk stratification in public reporting and evaluation of physician payment in all Medicare and Medicaid pay for performance value-based purchasing incentives or penalties to account for the challenges serving socioeconomically or medically underserved patient populations to ensure continued timely access to appropriate clinical services.

The AOA will support federal and state legislation, rules or regulations to improve Medicare and Medicaid payments to physicians working in socioeconomic, or medically underserved areas to ensure an adequate workforce to address the burden of care associated with complex comorbid conditions in these areas.

Source: H321 – A/22

Status: 2017; 2022 Reaffirmed as Amended

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Naloxone and other Opioid Antagonists

Policy Statement

The American Osteopathic Association (AOA) will work with legislators to give statutory protection in evaluation for and prescription of Naloxone and other opioid antagonists.

Source: H322-A/22

Status: 2017; 2022 Reaffirmed as Amended

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Shared Principles of Primary Care

Policy Statement

The American Osteopathic Association (AOA) endorses the “Shared Principles of Primary Care” as developed and published by the Patient-Centered Primary Care Collaborative (PCPCC).

Source: H323 – A/22

Status: 2017; 2022 Reaffirmed

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Eugenic Selection with Preimplantation Genetic Diagnosis

Policy Statement

The American Osteopathic Association supports legislation in collaboration with the medical community that regulates the use of Preimplantation Genetic Diagnosis (PGD) to choose a fetus' traits unrelated to disease.

Source: H324 – A/22

Status: 2016; 2021 Referred; 2022 Reaffirmed as Amended

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Interference Laws - Amendment to American Osteopathic Association Policy

Policy Statement

The American Osteopathic Association approved the following policy paper and recommendations to assist in responding to state and federal proposals and agencies that attempt to adopt interference laws.

INTERFERENCE LAWS (H358-A/19)
The American Osteopathic Association approved the following policy paper and recommendations to assist in responding to state and federal proposals and agencies that attempt to adopt interference laws (2013; 2019 Reaffirmed as Amended).

A number of states have pursued legislation that dictates how physicians treat and counsel patients during a medical exam. These laws interfere with the patient-physician relationship, and undermine physician judgment and represent a departure from evidence-based medicine. As a result, these laws are collectively referred to as “interference laws.”

Interference laws fall into one of four different classifications.[1] The first prevents physicians from asking their patients about risk factors that may affect their health or the health of their families (PHYSICIAN “GAG LAWS”). One example of a Gag Law is a 2011 Florida law which barred physicians from asking questions about a patient’s gun ownership.[2] The law was enjoined in 2012 on first amendments grounds, a decision which was upheld by a federal appeals court in 2017.[3] although 14 other states have considered similar laws, none have passed.[4]

The second type of interference law requires physicians to discuss specific treatments that may not be appropriate or medically necessary.[5] One example of this is New York’s Palliative Care Information Act of 2011, which requires health care providers to offer to discuss end-of-life options and palliative care services with terminally ill patients, without discretion as to how and when to raise the issues.[6] some argue that requiring physicians to discuss this subject with all patients is inappropriate, because physicians are not able to use their judgment to determine if or when patients should receive such sensitive information.

The third type of interference law requires physicians to provide tests or treatments which are not supported by evidence, including ones that are invasive or required without the patient's consent.[7] Examples of this are laws which require physicians who perform abortions to first perform a fetal ultrasound. It is argued that a fetal ultrasound is medically unnecessary and there is no legitimate medical purpose for requiring one in this circumstance.

The fourth ~~and final~~ type of interference law places restrictions on the content of information that physicians can disclose to patients.[8] Examples of this include laws which limit a physician from providing information about the dangers of chemicals used in the hydraulic fracturing process, also known as “fracking.”

~~RECENTLY~~ A FIFTH TYPE OF INTERFERENCE LAW HAS BEEN IDENTIFIED. THESE LAWS AND REGULATIONS INTERFERE IN THE PATIENT-PHYSICIAN RELATIONSHIP BY PROHIBITING, ~~OR~~ LIMITING, **OR MANDATING** PHYSICIANS ~~FROM DISCUSSING~~,

~~RECOMMENDING, AND/OR PROVIDING~~ **IN THE DISCUSSION , RECOMMEDATION AND/OR PROVISION OF** EVIDENCE BASED MEDICAL CARE OR TREATMENTS. AN EXAMPLE OF THIS ARE LAWS WHICH PROHIBIT OR LIMIT THE ABILITY OF PHYSICIANS TO PRESCRIBE CERTAIN MEDICATIONS BASED ON THE PHYSICIAN'S SPECIALTY.

Impact on the Osteopathic Medical Profession and the Patient-Physician Relationship
Interference laws threaten the osteopathic medical profession, in particular due to the intrusion into the patient-physician relationship, which is an essential component of the osteopathic care model's emphasis on preventive medicine and treatment of the whole patient.[9] The patient-physician relationship is based on ethical principles of trust, confidentiality, respect, autonomy and open communication between the physician and patient.[10]

Another critical element of osteopathic medical practice in general and the patient-physician relationship in particular is the concept of physician and patient autonomy and "patient-centered" care. The Institute of Medicine (IOM) defines patient-centered care as "providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."[11] Patient-centered care is an essential element in the practice of evidence-based medicine. The American Osteopathic Association (AOA) supports the use of evidence-based medicine and the implementation of appropriate methods to optimize natural healing and to address the primary cause of disease.

The patient-physician relationship is a critical aspect of osteopathic care, due in large part to a partnership that is created between the physician and patient which relies heavily on communication. "Osteopathic physicians (DOs) consider the impact that lifestyle and community have on the health of each individual, and they work to break down barriers to good health. DOs are trained to look at the whole person, and osteopathic physicians integrate the patient into the health care delivery process as a partner."[13] Interference laws which prevent DOs from discussing certain health-related subjects such as the safe storage of firearms or the health implications of fracking undermine this partnership and violate the osteopathic principle of preventive medicine. DOs help prevent pediatric deaths by counseling caregivers on the importance of seatbelt and helmet use, but without the ability to adequately counsel a patient on the importance of safe firearm storage they may be unable to help prevent similar deaths from improperly stored firearms. "[T]he purpose of [a firearms] inquiry is so that the practitioner can determine what subject matters require further follow-up in the practice of preventive medicine."[14] The AOA rejects any censorship of professional communication, supports enactment of legislation protecting the patient-physician relationship and opposes any attempt to interfere with the patient-physician relationship.[15]

Additionally, interference laws that require DOs to discuss treatments which are not medically necessary or are not supported by evidence-based guidelines violates the osteopathic principle of treating the whole patient and can undermine patient trust. In Kansas, for example, physicians are required to provide misleading information to patients regarding an unproven link between breast cancer and abortion.[16] Twenty-three states currently require health care providers to refer patients to state-created "informed consent" materials, and according to a 2016 audit by Rutgers University, 31 percent of the information included in these materials was found to be medically inaccurate.[17] Blanket requirements that DOs provide information on a particular treatment, or medically inaccurate information, to all patients prevents them from exercising their independent medical judgment and treating the whole patient in an objective, evidence-based manner. Similarly, interference laws which require DOs to perform certain procedures or treatments violate the osteopathic principle of providing

individualized patient-centered care. If a DO is required to perform a certain procedure or treatment for every patient, there is no individualized assessment as to what is in a particular patient's best interests and there is no discussion with the patient because the patient has no choice. Instead of individualized care, this is a "one size fits all" approach. Ultimately, DOs are prevented from rendering individualized, evidence-based care, and patients are prevented from being involved in patient-centered care.

Legal Challenges

Two types of interference laws have been challenged in court. Florida's controversial Firearm Owner's Privacy Act, which restricted physicians from asking patients about firearm ownership, was enjoined in June 2012 when a Florida district court found that it violated physicians' First Amendment rights, a decision which was upheld by a federal appeals court in 2017. In granting the injunction, the judge stated the law "chills practitioners' speech in a way that impairs the provision of medical care and may ultimately harm the patient."[18] The court also held that physician questioning did not violate patients' Second Amendment rights stating, "[t]he law does not affect nor interfere with a patient's right to continue to own, possess, or use firearms.

Protecting the right to keep and bear arms is irrelevant to this law."1[9] In addition, a similar 2012 law which prevented physicians in Pennsylvania from discussing how fracking chemicals may be affecting their patients' health was struck down by the state supreme court in 2016. [20]

Mandatory ultrasound laws have also been challenged on First Amendment grounds. North Carolina's mandatory ultrasound law was struck down as a violation of physician and patient First Amendment rights. The court held that "[t]he Act goes well beyond requiring disclosure of those items traditionally a part of the informed consent process. In this case, the state compels the provider to physically speak and show the state's non-medical message to patients unwilling to hear or see [that message]."[21]

Conversely, a nearly identical Kentucky law was upheld by a federal appeals court, which found that the law was reasonably related to the "informed consent" process and did not violate the First Amendment rights of physicians and patients.[22] Significantly, the circuit split between the courts sets up a probable hearing by the United States Supreme Court on the issue of mandatory ultrasound laws.

Mandatory ultrasound laws have also been challenged in court on Fourteenth Amendment Substantive Due Process grounds. A mandatory ultrasound law in Oklahoma was ruled to be unconstitutional as a violation of patients' Fourteenth Amendment due process rights, because it placed an "undue burden" on a woman's right to seek an abortion.[23]

Efforts of Medical Associations

Several medical associations have developed policies or taken action in opposition to interference laws. In 2015, the American Medical Association (AMA) reaffirmed a 2011 resolution which opposes any intrusion into patient-physician relationships and supports physician judgment. In May 2018, the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists and the American College of Physicians issued a set of joint principles based upon their organizations' policies which oppose governmental interference with physicians' obligations to provide comprehensive, evidence-based information to patients.[25]

The American Bar Association (ABA) also has policy specifically opposing laws which prevent physicians from asking patients about firearm ownership. The ABA policy states that these laws

clearly violate the First Amendment rights of physicians and patients, and physician questioning does not in any way violate Second Amendment rights of patients.[26]

Finally, several state medical associations have adopted resolutions on the issue of interference laws. Many of these policies are very basic and simply state the association's opposition to any interference with the patient-physician relationship. Additionally, these policies often promote the use of evidence-based medicine, seek to preserve physician judgment and support litigation which blocks the enforcement of interference laws.

Conclusion

The AOA supports the protection of the patient-physician relationship as especially paramount to the osteopathic medical profession. The osteopathic care model is based upon the treatment of the whole patient and the use of preventive medicine. The patient-physician relationship is a fundamental aspect of osteopathic care, due in large part to a partnership that is created between the physician and patient which relies heavily on communication and trust. Interference laws encroach on this relationship and undermine the osteopathic care model by preventing DOs from providing treatment in a manner that is based upon evidence they believe is best for their patients.

The AOA affirms that legislation which interferes with the patient-physician relationship impairs the autonomy of osteopathic physicians and prevents osteopathic physicians from using their independent medical judgment based on years of rigorous education and training.

The AOA asserts that physicians must be able to communicate freely with patients without fear of government intrusion in order to assure safe, comprehensive and effective medical treatment.

The AOA considers legislation that undermines physician judgment to be a barrier to evidence-based medicine.

The AOA supports the use of evidence-based medicine to ensure high quality patient care. Statutorily required medical practices interfere with evidence-based medicine by mandating a "one size fits all approach," thereby preventing an individualized assessment of what is in a particular patient's best interests.

The AOA affirms that legislation which interferes with the patient-physician relationship undermines patient-centered care. Patient-centered care actively involves the patient in making decisions regarding their own medical care. Statutorily required medical practices prevent patients from being involved in making medical decisions, because the patient has no choice.

The AOA believes that the ethical principle of informed consent is undermined when patients are statutorily required to undergo certain treatments or procedures, because the patient has no choice.

The AOA opposes all legislation at the state and federal level that requires physicians to discuss or perform certain treatments or procedures not supported by evidence-based guidelines, because such legislation undermines physician judgment.

The AOA opposes all legislation at the state and federal level which prevents physicians from discussing certain health-related risk factors with their patients, because such legislation violates the First Amendment rights of physicians and patients and is in conflict with evidence-based medical best practices.

The AOA believes that physicians should be free to counsel patients on end-of-life care on a case-by-case basis rather than as a result of an across-the-board mandate.

The AOA supports legal challenges to interference laws that violate First Amendment and Fourteenth Amendment rights of physicians and patients under the State and Federal Constitutions.

THE AOA OPPOSES ALL LEGISLATION AT THE STATE AND FEDERAL LEVEL WHICH PREVENTS, **LIMITS, OR MANDATES PHYSICIANS** FROM DISCUSSING, RECOMMENDING, OR PROVIDING AN EVIDENCE BASED TREATMENT WHICH IN THE PHYSICIAN'S **CLINICAL** JUDGMENT IS IN THE PATIENT'S BEST INTEREST BECAUSE SUCH LEGISLATION **ERODES THE SANCTITY OF THE PATIENT-PHYSICIAN RELATIONSHIP AND** UNDERMINES THE PHYSICIAN'S **CLINICAL** JUDGMENT.

The AOA will monitor state and federal interference laws on an ongoing basis and update this policy as needed.

Source: H325 – A/22

Status: 2022 Reaffirmed as Amended

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Adolescents' Bill of Rights

Policy Statement

The American Osteopathic Association (AOA) advocates that all medical facilities which provide care for adolescents post an "Adolescents' Bill of Rights" that clearly articulates state and local applicable laws of consent and confidentiality regarding health care for adolescents who have not reached the age of majority.

Source: H300-A/23

Status: 2003; 2008 Reaffirmed; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted

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Direct to Consumer Advertising in Drugs

Policy Statement

The American Osteopathic Association (AOA) opposes direct to consumer advertising of prescription drugs. The AOA opposes direct to consumer advertising of prescription medicines and will work with legislative bodies and advocacy organizations to make direct to consumer advertising of pharmaceuticals illegal in the United States consistent with World Health Organization recommendations.

Source: H302-A/23

Status: 2001; 2003 Reaffirmed as Amended, 2005; 2010 Reaffirmed as Amended; 2015 Reaffirmed; 2018 Reaffirmed; 2023 Adopted

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Discrimination Against Osteopathic Physicians

Policy Statement

The American Osteopathic Association (AOA) will continue to ensure that legislation and regulatory policy specifies that any reference at the national level in an executive order, an administrative regulation, or in the federal revised statutes to “medical doctor”, “MD”, “physician”, “allopathic physician”, an allopathic medical specialty board, or reference to any medical student, or postgraduate, shall include and pertain to a “doctor of osteopathic medicine”, “DO”, AOA specialty board, and osteopathic medical students and postgraduates.

Source: H303-A/23

Status: 2013; 2018 Reaffirmed; 2023 Adopted

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Durable Medical Equipment Claims Processing

Policy Statement

The American Osteopathic Association (AOA) remains committed to cost effective healthcare and supports a reexamination of federal policy regarding the timely processing of claims for durable medical equipment.

Source: H304-A/23

Status: 1993; 1998 Reaffirmed as Amended, 2003; 2008 Reaffirmed; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Adopted as Amended

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Equality in the Military

Policy Statement

The American Osteopathic Association (AOA), as the main representative of the osteopathic profession, support that all uniformed service personnel, which includes military physicians, DO or MD, who are physically and operationally qualified are to be recognized as members of the military in the United States without regard to race, color, creed, national origin, medical degree, gender, gender identity or sexual preference; and that the AOA oppose any attempt, either by legislation, directive or hierarchal order, that seeks to infringe upon this status.

Source: H305-A/23

Status: 2018; 2023 Adopted as Amended

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Federal Student Loan Program

Policy Statement

The American Osteopathic Association (AOA) recommends that the Federal Student Loan Program reduce interest rates to the lowest possible. The AOA recommends that the Federal Student Loan Program defer any interest to the loan until training is completed and that all student loan interest be tax deductible regardless of income. AOA supports affiliate efforts to ensure that forgiven student loan amounts are not counted as taxable income.

Source: H306-A/23

Status: 2018; 2023 Adopted as Amended

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Government Funding for COCA and LCME Accredited Medical Schools and Students Attending Such Institutions

Policy Statement

The American Osteopathic Association (AOA) will advocate for policies that promote and prioritize access for United States citizens and permanent residents who attend Commission on Osteopathic College Accreditation (COCA) and Liaison Committee on Medical Education (LCME) certified medical schools to post-graduate training programs at U.S.-based institutions, by advocating for policies that restrict access to student loans for students attending non-COCA and non-LCME certified medical schools; oppose agreements between U.S. hospitals and other health care entities that receive local, state and federal funds that discriminate against or restrict training opportunities for students of COCA and LCME accredited colleges of medicine; limit agreements between non-COCA and non-LCME certified medical schools and U.S. institutions that receive local, state or federal funding in which there is training of non-COCA or non-LCME certified medical schools for longer than 12 weeks in order to promote equal access for U.S. citizens and permanent residents; promote a structure that ensures that federal or state funding provided to U.S. institutions for the training of medical students be proportional to the percentage of COCA and LCME medical school students that it trains; prohibit the use of local, state and federal funds for non-U.S. citizens that attend non-COCA or non-LCME certified medical schools; and distribute local, state and federal funding for U.S. citizens and permanent residents that attend non-COCA or non-LCME certified medical schools proportionally to U.S. citizens and permanent residents who attend COCA or LCME certified medical schools.

Source: H307-A/23

Status: 2013; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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Health Care that Works for All Americans

Policy Statement

The American Osteopathic Association (AOA) encourages the U.S. Congress to pass legislation that addresses the major issues that threaten the ability of osteopathic physicians to provide high quality, cost-efficient health care to their communities, including the availability of affordable health insurance for all citizens; and supports the payment to osteopathic physicians, and training institutions, osteopathic manipulative services on payor reimbursement.

Source: H308-A/23

Status: 2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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Medicare Limiting Charge / RBRVS System

Policy Statement

The American Osteopathic Association (AOA) opposes Medicare's limiting charge ceiling.

Source: H309-A/23

Status: 1989; 1993 Reaffirmed as Amended, 1998, 2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted

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Medicare User Fees

Policy Statement

The American Osteopathic Association (AOA) opposes any legislation that would establish Medicare user fees.

Source: H310-A/23

Status: 1998, 2003 Reaffirmed as Amended; 2008; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted

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Medicare

Policy Statement

The American Osteopathic Association (AOA) declares its continued support of the Medicare program, the continued availability of high quality medical care at a reasonable cost and comprehensive Medicare reform to ensure that Medicare beneficiaries receive medically necessary services.

Source: H311-A/23

Status: 1966; 1978 Reaffirmed; 1983 Reaffirmed as Amended, 1988, 1993, 1998, 2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted as Amended

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Physicians in Health Professional Shortage Areas – Model Funding to Increase

Policy Statement

The American Osteopathic Association (AOA) encourages state and federal U.S. medical student funding agencies to provide loans to U.S. citizens and permanent residents who commit to practice in federally designated Health Professional Shortage Areas (HPSAs) and encourages state and federal U.S. medical student funding agencies to provide medical school loan forgiveness for U.S. citizens and permanent residents for each year they practice in a federally designated HPSA.

Source: H312-A/23

Status: 2013; 2018 Reaffirmed as Amended; 2023 Adopted

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Primary Care Physicians Programs in Health Professional Shortage Areas (HPSAS) – Funding to Increase

Policy Statement

The American Osteopathic Association (AOA) encourages state and federal agencies to provide funds to U.S. osteopathic and allopathic medical schools to develop and maintain informational curricula programs, and mentor U.S. citizens and permanent residents from federally designated Health Professional Shortage Areas (HPSAs), from high school through the first year in primary care practice which encourages long-term primary care medical practice in HPSAs; further, the AOA encourages state and federal agencies to provide loan forgiveness for graduates of osteopathic and allopathic medical schools for the loans related to their medical school education for each year they deliver the informational curriculum and mentoring services to U.S. citizens and permanent residents from federally designed HPSAs from high school through the first year in primary care practice, which encourages long-term primary care practice in federal designated HPSAs.

Source: H313-A/23

Status: 2013; 2018 Reaffirmed; 2023 Adopted as Amended

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Rural Healthcare Payment Equity

Policy Statement

The American Osteopathic Association (AOA) endorses equity in reimbursement for rural physicians as part of the strategy to increase the availability of quality healthcare in rural areas.

Source: H314-A/23

Status: 1988; 1993 Reaffirmed as Amended; 1998 Reaffirmed, 2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted

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Uninsured – Access Health Care

Policy Statement

The American Osteopathic Association (AOA) supports federal and state efforts to increase access to affordable health care coverage through initiatives that expand coverage to the uninsured through the efficient use of both private and public resources and supports efforts to reform programs such as Medicaid, Medicare, and State Child Health Insurance Program (SCHIP) to provide coverage to populations that would otherwise lack health care coverage and ultimately, access to needed health care services.

Source: H315-A/23

Status: 2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted

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Terminology – Volunteer Osteopathic Medical Health Care Delivery

Policy Statement

The American Osteopathic Association (AOA) recommends that the osteopathic medical profession use the following terms to more clearly describe their specific activities when delivering volunteer and/or elective medical care domestically or globally.

- Osteopathic Medical Outreach, Osteopathic Global Health or Global Health Outreach – secular-based volunteer work programs outside the everyday practice of an osteopathic physician or physician-in-training, generally carried out in underserved areas, either domestic or global.

- Osteopathic Medical Mission or Medical Mission – health care activities with specifically religious connotations, affiliations or work.

- Humanitarian Relief or Osteopathic Medical Response – efforts or programs providing health care assistance and humanitarian aid in emergency situations or disaster relief.

- Osteopathic Medical Exchanges or Osteopathic Medical Rotations / Clerkships – formal institutional partnerships with international entities (e.g., ministries of health, medical institutions, organizations, etc.) that may include sending or receiving osteopathic physicians, physicians-in-training, or other health care trainees for education or outreach programs, to include elective or non-elective osteopathic medical school or residency rotations/ clerkships.

Source: H316-A/23

Status: 2013; 2018 Reaffirmed; 2023 Adopted

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Osteopathic Medicine Definition

Policy Statement

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

Source: H317-A/23

Status: 1991;1992 Reaffirmed as Amended, 1997, 1998, 2003 Reaffirmed; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Adopted

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Health Care Providers Right of Conscience

Policy Statement

The American Osteopathic Association (AOA) believes osteopathic physicians are ethically bound to inform patients of available options with regard to treatment and if an osteopathic physician has an ethical, moral or religious belief that prevents them from providing a medically-approved service, they should recuse themselves from that aspect of care and refer the patient to another provider or location.

Source: H318-A/23

Status: 2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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Physician Health Assistance

Policy Statement

The American Osteopathic Association (AOA) supports continued assistance in the rehabilitation of the impaired osteopathic physicians through its Bureau of Membership.

Source: H319-A/23

Status: 1973; 1978 Reaffirmed; 1983 Reaffirmed as Amended, 1988, 1993, 1998, 2003; 2008 Reaffirmed as Amended; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Adopted

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Social Media Guidelines – Implementation of

Policy Statement

The American Osteopathic Association (AOA) supports the use of appropriate social media by osteopathic physicians as a method to promote our profession and practices.

Source: H320-A/23

Status: 2013; 2018 Reaffirmed; 2023 Adopted as Amended

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Alcohol and Tobacco – Advertising Ban on

Policy Statement

The American Osteopathic Association (AOA) supports a ban on all advertising of tobacco products and alcohol.

Source: H321-A/23

Status: 1988; 1993 Reaffirmed as Amended; 1998 Reaffirmed; 2003 Reaffirmed as Amended; 2008 Reaffirmed; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted as Amended

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Obesity – Health Plans should include Benefits for Treatment of

Policy Statement

The American Osteopathic Association (AOA) supports the inclusion of medical, surgical behavioral health nutritional counseling and physical conditioning as a paid benefit for members of all health plans for the prevention and treatment of obesity.

Source: H322-A/23

Status: 2003; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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Osteopathic Manipulative Treatment (OMT) for Low Back Pain

Policy Statement

The American Osteopathic Association (AOA) supports the attached white paper entitled "Osteopathic Manipulative Treatment (OMT) for Low Back Pain.".

Background

The American Osteopathic Association first published clinical practice guidelines for Osteopathic Manipulative Treatment (OMT) for Patients with Low Back Pain in 2010.[1] The revision of the guidelines was approved by the AOA House of Delegates in 2015 and published in the JAOA in 2016.

The summary of the guidelines states:

The American Osteopathic Association recommends that osteopathic physicians use Osteopathic Manipulative Treatment (OMT) in the care of patients with low back pain. These guidelines update the AOA guidelines for osteopathic physicians to utilize OMT for patients with nonspecific acute or chronic LBP. Evidence from systematic reviews and meta-analyses of randomized clinical trials (Evidence Level 1a) supports this recommendation.[2]

Both versions of the guidelines were accepted for inclusion in the National Guideline Clearinghouse (NGC). NGC is an initiative of the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. (https://www.guideline.gov/). The NGC mission is to provide physicians and other health care professionals, health care providers, health plans, integrated delivery systems, purchasers and others an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines and to further their dissemination, implementation, and use

The current guidelines are based on a systematic review of the literature on OMT for patients with low back pain and a meta-analysis of all randomized controlled trials of OMT for patients with low back pain in ambulatory settings by Franke et al.[3] Additionally, they build upon the 2010 AOA Clinical Practice Guidelines for Low Back Pain1 and the 2005 systematic review by Licciardone et al.[4] on which the previous guidelines were based. Franke et al.'s conclusions further strengthen the findings that OMT reduces LBP. Franke et al. specifically state that clinically relevant effects of OMT were found for reducing pain and improving functional status in patients with acute and chronic nonspecific LBP and for LBP in pregnant and postpartum women at 3 months post treatment. [3]

Evidence review for the 2015 Guidelines
In August 2014, a member of the AOA Low Back Pain Task Force conducted a literature search using keywords including back pain, low back pain, Osteopathic Manipulative Treatment (OMT), osteopathic, manual therapy and randomized controlled trials (RCT) in PubMed, CINAHL, Science Direct, and Springer Link databases from 2003-2014. During this search, the systematic review by Franke et al. published in August 2014 was discovered and a

determination was made to base the revised guidelines on this publication. At the same time, personal communications yielded two additional articles by Hensel[5] and Licciardone[6] published after the literature review by Franke et al. No other studies were identified.

Two members of the AOA Low Back Pain Task Force reviewed the research design of these studies according to the methods used in the Franke et al. systematic review and determined that both articles met the rigorous criteria applied by the Franke et al researchers. As stated in the Franke et al. publication: "Only randomized clinical trials were included; specific back pain or single treatment techniques studies were excluded. Outcomes were pain and functional status. GRADE was used to assess quality of evidence." Franke et al. also concluded that "larger, high-quality randomized controlled trials with robust comparison groups are recommended."

Both Hensel's and Licciardone's studies were larger than any previous studies and were high quality RCTs with robust comparison groups. The Task Force concluded that these studies were of high quality and low bias in the sense that they incorporated randomization, blinding, baseline comparability between groups, and addressed patient compliance and attrition. The Task Force agreed that these two articles would have met the inclusion criteria of the Franke et al. team and would have been included in the Franke et al. systematic review had they been published earlier. The Task Force believes that the conclusions of the studies support the guidelines and are not contradictory to them. Therefore, they were included in the AOA guidelines.

Results

As stated in the 2016 AOA Guidelines for Osteopathic Manipulative Treatment (OMT) for Patients with Low Back Pain[2], OMT significantly reduces pain and improves functional status in patients, including pregnant and postpartum women, with nonspecific acute and chronic LBP.

OMT versus other interventions for acute and chronic nonspecific low back pain:
Franke et al.[3] found that in acute and chronic non-specific LBP, moderate-quality evidence suggested OMT had a significant effect on pain relief (MD:-12.91, 95% CI: -20.00 to -5.82) and functional status (SMD:-0.36, 95% CI: -0.58 to - 0.14).

OMT versus other interventions for chronic nonspecific low back pain:
More specifically, in chronic nonspecific LBP, the evidence from Franke et al[3] suggested a significant difference in favor of OMT regarding pain (MD:-14.93, 95% CI:-25.18 to -4.68) and functional status (SMD:-0.32, CI:-0.58 to -0.07).

OMT versus untreated for nonspecific low back pain in postpartum women:
For nonspecific LBP postpartum, Franke et al.[3] found that moderate-quality evidence suggested a significant difference in favor of OMT for pain (MD: -41.85; 95% CI: -49.43 to -34.27) and functional status (SMD: -1.78; 95% CI: -2.21 to -1.35).

OMT versus usual obstetric care, sham ultrasound, and untreated for nonspecific low back pain in pregnant women:
When examining nonspecific LBP in pregnancy, Franke et al.[3] found low-quality evidence that suggested a significant difference in favor of OMT for pain (MD: -23.01; 95% CI: -44.13 to -1.88) and functional status (SMD:-0.80; 95% CI: - 1.36 to -0.23).

Two other important studies published subsequent to the Franke et al. systematic review address LBP in pregnant women and enhance the findings of Frank et al. Hensel et al.[5] found that OMT was effective for mitigating pain and functional deterioration compared with usual care

only; however, OMT did not differ significantly from placebo ultrasound treatment. In yet another study conducted by Licciardone et al.[6], the investigators found that during the third trimester of pregnancy OMT has medium to large treatment effects in preventing progressive back-specific dysfunction.

Next Steps

Since the systematic review for the current guidelines was completed, additional studies supporting the use of OMT for low back pain have been published.[7-11] Licciardone et al. found that an OMT regimen for chronic low back pain showed significant and relevant measures for recovery[7], and that subgroup analysis by baseline levels of chronic low back pain is a simple strategy to identify patients who have substantial improvement with OMT.[8] Hensel et al. evaluated the safety of an OMT protocol9 during the third trimester of pregnancy and determined that the protocol is safe with regard to labor and delivery outcomes.[10] In a systematic review and meta-analysis, Franke et al. looked at the effectiveness of OMT for low back pain in pregnant or postpartum women and found that OMT produces clinically relevant benefits for this population.[11]

The current guidelines were approved by the AOA House of Delegates in 2015 and thus will sunset in 2020. Therefore, the AOA will need to revise the guidelines for submission to the 2020 HOD. The National Guideline Clearinghouse also requires a revision every five years for posting to their website. (Please note that as of this writing, funding to support the NGC has not yet been secured beyond July 16, 2018; NGC has established a cut-off date of March 5, 2018 for guideline submissions. The future of the NGC is still unclear.) Revision of the guidelines will require a new systematic review and meta-analysis of the literature. Staff anticipates beginning the revision process for the guidelines in the spring of 2019.

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Source: H323-A/23

Status: 2018; 2023 Adopted

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Physician Fees and Charges

Policy Statement

The American Osteopathic Association (AOA) upholds the following policy on Physician Fees and Charges.

PHYSICIAN FEES AND CHARGES

1. Physician's Fees
   A physician's fees should be based on the medical services provided to the patient, with due respect for:
   a. The difficulty and/or uniqueness of the services;
   b. The time, skill, and experience required;
   c. Customary fees charged for the same service in the same community;
   d. Overhead and professional liability costs.

2. Excessive Fees
   A physician should not collect excessive fees.

3. Reduced Fees
   A physician has the right to offer his/her services at a reduced fee, or without fee, when hardships exist or professional courtesy dictates, if he/she desires to do so.

4. Specialty Designation
   A fee should not be dependent upon a physician's specialty designation but upon the services provided. Any physician who provides a service for which he/she is properly trained has the right to charge the prevailing rate for such service, whether the service is performed by a family physician, a surgeon, an internist, or any other specialist.

5. Contingency Fees
   A physician's fees should be based directly on professional services rendered and not contingent on uncertain outcome. It is, therefore, deemed unethical for a physician to charge contingency fees.

6. Division of Fees
   Group practices and partnerships may ethically divide income based on service, contribution to the group, and/or contractual obligations.

7. Fee Splitting
   No physician may ethically split a fee to, or accept a fee from, another physician solely for the referral of a patient nor shall a physician accept payments from a hospital, clinic, laboratory, or other healthcare facility based upon patient referrals to that establishment. Surgeons may ethically engage other physicians to assist in the performance of a surgical procedure; however, the financial arrangements should be made known to the patient. This principle applies whether or not the assisting physician is the referring physician.

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8. Referrals to Suppliers
   Physicians shall not accept payment of any kind from any source such as a hospital, clinic, laboratory, pharmaceutical company, device manufacturer, pharmacist or other healthcare provider or supplier, for referring patients to said facility or prescribing such entity's products. All referrals and prescriptions must be based on the patient's needs and sound medical decision-making, all in the patient's best interest.

9. Form Completion Charges
   A physician may charge for completion of forms.

10. Copying Charges
    A physician may charge the prevailing rate for the copying of patient records and postage incurred in mailing.

11. Missed Appointments
    A physician may ethically charge for missed appointments, or appointments cancelled less than 24 hours in advance, provided:
    a. The patient has been previously notified in writing of the policy;
    b. Utmost consideration is given to the patient, including the circumstances involved;
    c. The practice is resorted to infrequently;
    d. The physician's patient load is considered.

12. Delinquent Accounts
    Harsh or grossly commercialized collection practices are discouraged. If a physician has experienced problems dealing with patients who have delinquent accounts, he/she may properly request payment for service at the time of treatment, or may add interest or other late-payment charges in accordance with state and federal laws. The patient must be notified of such a policy in advance by one or more of the following:
    a. Posting a notice in the waiting room;
    b. Distribution of patient handbooks containing the policy;
    c. Notification by special letter;
    d. Notation of the policy on the billing statement before the charge is incurred.

The American Osteopathic Association encourages physicians to make exceptions to implementing these collection charges in cases of financial hardship, after consultation with the involved patient.

The exception to waiving collection charges is the patient who receives payment for medical services from his/her insurance company, and then fails to make payment to the physician. In this case, all legal pressure may be brought to bear on the patient and the insurance company in order to discourage this practice, both by the insurance company and by the patient.

13. Legal Restrictions
    The foregoing statements are subject to any restrictions imposed by any state and federal laws or contractual obligations.:

Source: H324-A/23

Status: 1998, 2003 Reaffirmed; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Adopted as Amended

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Physician Payment for Electronic Advice, Counseling and Treatment Plans

Policy Statement

The American Osteopathic Association (AOA) recognizes that the ability for physicians to provide telemedicine services and be compensated, is necessary to improve access to care for all patients.

The AOA strongly encourages payers to include as a benefit for physicians to receive payment parity for professional advice, consultation and development of patient treatment plans provided to patients, family members or designee via telemedicine.

The AOA recognizes that creating infrastructure and policies for telemedicine is necessary to improve outcomes.

Source: H325-A/23

Status: 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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Electronic Health Records – Drug Interaction Warnings

Policy Statement

The American Osteopathic Association (AOA) supports ongoing evaluation and improvement of drug interaction severity warnings in electronic health records (EHR) and will collaborate with EHR companies to correct inappropriate severity warnings.

Source: H326-A/23

Status: 2013; 2018 Reaffirmed; 2023 Adopted as Amended

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Evaluation and Management Documentation Guidelines

Policy Statement

The American Osteopathic Association (AOA) advocates for the use of an independent profession/specialty matched medical peer review process for physicians identified as outliers; opposes the continuation of random pre-payment audits of claims; advocates that any auditing of outpatient medical records be conducted on a retrospective post-payment basis and is statistically sound using determinations in effect at the time of claim; opposes the practice that requires physicians to repay alleged over-payments before all appeal remedies have been exhausted; advocates immunity from Medicare sanctions for physicians voluntarily participating in Medicare sponsored alternative payment models; advocates that Centers for Medicare and Medicaid Services (CMS) develop educational programs that help physicians identify mistakes or misunderstandings with their coding so as to avoid civil penalties.

Source: H327-A/23

Status: 2003; 2008 Reaffirmed as Amended; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Adopted

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Healthcare Practice – Patient-Physician Relationship and

Policy Statement

The American Osteopathic Association (AOA) believes that it is the responsibility of the osteopathic physician to advocate for the rights of their patients, regardless of any contractual relationship and that the patient-physician relationship shall not be altered by any system of healthcare practice which may place economic considerations above the interest of patients.

Source: H328-A/23

Status: 1998, 2003 Reaffirmed; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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Mandatory Assignment

Policy Statement

The American Osteopathic Association (AOA) supports the right of physicians to accept assignments of payments on a case-by-case basis.

Source: H329-A/23

Status: 1988; 1993 Revised; 1998 Reaffirmed, 2003 Revised; 2008; 2013 Approved; 2018 Approved; 2023 Adopted

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Medical Records-Policy / Guidelines for the Maintenance, Retention, and Release of

Policy Statement

The American Osteopathic Association (AOA) supports the use of appropriate single ICD codes should suffice to justify the ordering of laboratory tests, if those tests are ordered as part of the evaluation of a disease process or in the context of an already known disease; and the AOA will communicate this policy to the Centers for Medicare and Medicaid Services, the Department of Health and Human Services, health insurance companies and to the U.S. Congress.

MEDICAL RECORDS-POLICY / GUIDELINES FOR THE MAINTENANCE, RETENTION AND RELEASE OF

The American Osteopathic Association urges osteopathic physicians to become familiar with the applicable laws, rules or regulations on retention of records and patient access to medical records in their states; and approves the following Policy/ Guidelines for the Maintenance, Retention and Release of Medical Records

POLICY/GUIDELINES FOR THE MAINTENANCE, RETENTION AND RELEASE OF MEDICAL RECORDS

A. Release of records*:* The record is a confidential document involving the osteopathic patient-physician relationship and shall not be communicated to any other person or entity without the patient's prior written consent, unless required by law. Transmission of patient data to a third party shall only entail the minimum necessary to achieve the intended purpose**.** Under The Health Insurance Portability and Accountability Act of 1996 (HIPAA), patients have the right to request access to review and copy certain information in their medical records. In addition, HIPAA provides patients with the right to request an amendment to health information in their medical records. HIPAA also provides patients with the right to request an "accounting of disclosures" of their protected health information. Upon written request of the patient, an osteopathic physician shall provide a copy of, or a summary of, the record to the patient or to another physician or other provider, an attorney, or other person or entity authorized by the patient as provided by law. Medical information shall not be withheld because of an unpaid bill for medical services.

B. Records upon retirement or departure from a group*:* A patient's records may be necessary to the patient in the future not only for medical care but also for employment, insurance, litigation or other reasons. When an osteopathic physician retires or dies, patients shall be notified in a timely manner and urged to find a new physician and shall be informed that, upon authorization, records will be sent to the new physician. Records which may be of value to a patient, and which are not forwarded to a new physician shall be retained consistent with the privacy requirements under federal and/or state laws and regulations, either by the treating osteopathic physician, or such other person lawfully permitted to act as a custodian of the records. The patients of an osteopathic physician who leaves a group practice must be notified that the osteopathic physician is leaving the group. It is unethical to withhold the address of the departing osteopathic physician if requested by the patient or his or her authorized designee. If the responsibility for notifying patients falls to the departing osteopathic physician rather than to

the group, the group shall not interfere with the discharge of these duties by withholding patient lists or other necessary information.

C. Sale of medical practice**:** In the event that an estate of, or the practice of an osteopathic physician's medical practice is sold, the assets of such practice or estate, both hard and liquid, should be transferred in a mutually agreeable manner consistent between seller and buyer. If medical records of the estate or of the practicing physician are included in such sale they should be transferred between seller and buyer in accordance with state and federal guidelines to remain compliant with the confidentiality rules and regulations which govern the security of such records, allowing the buyer to have the opportunity to continue caring for those patients.

All active patients should be notified that the osteopathic physician (or the estate) is transferring the practice to another physician who will retain custody of their records and that at their written request, within a reasonable time as specified in the notice, the records or copies will be sent to any other physician of their choice. Rather than destroy the records of a deceased osteopathic physician, it is better that they be transferred to a practicing physician who will retain them consistent with privacy requirements under federal and/or state laws and regulations and subject to requests from patients that they be sent to another physician. A reasonable charge may be assessed for the cost of duplicating records. Any sale of a medical practice should conform to IRS and federal guidelines.

D. Retention of records**:** Osteopathic physicians have an obligation to retain patient records. The following guidelines are offered to assist osteopathic physicians in meeting their ethical and legal obligations:

1. Medical considerations are the principal basis for deciding how long to retain medical records. For example, operative notes and chemotherapy records should always be part of the patient's chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether an osteopathic physician would want the information if he or she were seeing the patient for the first time.

2. If a particular record no longer needs to be kept for medical reasons, the osteopathic physician should check state laws to see if there is a requirement that records be kept for a minimum length of time. Most states will not have such a provision. If they do, it will be part of the statutory code or state licensing board.

3. In all cases, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice claims. The statute of limitations may be three or more years, depending on the state law. State medical associations and insurance carriers are the best resources for this information. If a patient is a minor, the statute of limitations for medical malpractice claims may not begin to run until the patient reaches the age of majority.

4. Whatever the statute of limitations, an osteopathic physician should measure time from the last personal professional contact with the patient.

5. The records of any patient covered by Medicare or Medicaid must be kept in accordance with the respective regulations.

6. In order to preserve confidentiality when discarding old records, all documents should be destroyed. Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity.

Source: H330-A/23

Status: 1998; 2003 Reaffirmed as Amended; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Adopted as Amended

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Osteopathic Manipulative Treatment and Evaluation & Management on the Same Day of Service – Payment for

Policy Statement

The American Osteopathic Association (AOA) supports payment for osteopathic manipulative treatment (OMT) and evaluation and management services separately when performed on the same day of service and supported by documentation.

Source: H331-A/23

Status: 1998, 2003 Reaffirmed as Amended; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Adopted as Amended

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Patient Confidentiality

Policy Statement

The American Osteopathic Association (AOA) policy supports that in such cases where the physician is bound by law to protect patient confidentiality, the physician shall only be required to provide information that can be disclosed under law and where possible, the physician shall be allowed to submit narrative reports or only copies of the part of a medical record that is pertinent in lieu of a complete record.

Source: H332-A/23

Status: 1993; 1998 Reaffirmed; 2003 Reaffirmed as Amended; 2008; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted

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Pre-Filled Medical Necessity Form

Policy Statement

The American Osteopathic Association (AOA) encourages physicians to verify directly with patients that the patient is in need of supplies; and the AOA supports disclosure regarding medical necessity and making it inappropriate for supply companies to provide physicians with medical necessity certification forms on which the quantity or indication of a need for a product is pre-filled.

Source: H333-A/23

Status: 2008; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted

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Referrals and Consults – Non-Physician Disclosures

Policy Statement

The American Osteopathic Association (AOA) recommends that a patient referred to a physician specialist should be seen and evaluated by a physician specialist. Any care by a non-physician in a specialist's office / clinic should be disclosed to the patient and referring physician before the care is provided.

Source: H334-A/23

Status: 2008; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted

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Tobacco Use

Policy Statement

The American Osteopathic Association (AOA) supports third-party coverage of evidence-based approaches for the treatment of tobacco use and nicotine withdrawal.

Source: H335-A/23

Status: 1998; 2003 Reaffirmed as Amended; 2008 Reaffirmed as Amended; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted

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Uniform Billing

Policy Statement

The American Osteopathic Association (AOA) opposes charging a fee or other penalty to physicians for the payment claims that they submit for care provided to Medicare and Medicaid patients.

Source: H336-A/23

Status: 1993; 1998 Reaffirmed as Amended, 2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted

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Expert Witness & Peer Review

Policy Statement

The American Osteopathic Association (AOA) approves the Expert Witness and Peer Review policy.

EXPERT WITNESS & PEER REVIEW WHITE PAPER

Introduction:
The days when physicians would not testify against fellow colleagues because they did not want to break the code of silence previously associated with the profession are long over. [1] Today, it is common practice for physicians to serve as medical experts in medical malpractice actions. The 1993 U.S. Supreme Court case Daubert v. Merrell Dow Pharmaceutical gave the Court an opportunity to establish guidelines for expert witness testimony. The Court concluded that expert witness testimony should be scientifically valid. Additionally, the Court said that testimony is valid if there has been peer review and general acceptance of the testimony.

There is a great deal of skepticism about the role of the physician-expert, and whether an expert's testimony is valid.[2] Some physicians travel the country routinely testifying in malpractice actions, and in many instances they are considered "hired guns" who will alter their opinions for the highest bidder.[3] Concern over speculative expert testimony has led critics to call for stricter scrutiny of expert testimony and to appeal to professional organizations to take a more active role in monitoring physicians who give inaccurate testimony.[4]

Peer Review of Osteopathic Manipulative Treatment
The integrity of both judicial and administrative proceedings regarding physicians and alleged medical malpractice depends in part on the honest, unbiased testimony of expert witnesses. Such testimony serves to clarify and explain technical concepts and to articulate professional standards of care. To that end, the AOA has adopted the policy that "osteopathic physicians acting as medical directors, expert witnesses, or peer reviewers, and affecting patient treatment, outcome of care, and access to care, are practicing osteopathic medicine." This statement suggests that expert witness testimony should be subject to peer review.

The introduction of a peer review requirement, however, presents an interesting question for osteopathic physicians: namely, should MDs be allowed to review the work of osteopathic physicians without the input of another DO? One of the important elements of osteopathic training is osteopathic manipulative treatment (OMT), a practice unique to the osteopathic profession. Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine (NMM/OMM) is a unique specialty within the osteopathic profession that should be reviewed by a like peer. Because both DOs and MDs are licensed for the unlimited practice of medicine in all 50 states, members of either branch of the medical profession can generally testify concerning the actions of the members of the other branch of the profession. However, considering the uniqueness of OMT, MDs will not likely have the education or training to determine if the actions of osteopathic physicians using OMT were within the appropriate standard of care.

In addition, peer review takes place in both hospital and outpatient settings, and by third party payers. Various entities—including the Centers for Medicare and Medicaid Services, managed care organizations, third party payers, and workers' compensation programs—often use peer review for determinations in reimbursement decisions. In addition, many insurance carriers have claims for the service of OMT "peer reviewed" by health care providers that are either not trained or who are inadequately trained in Osteopathic Principles and Practices. Osteopathic physicians are highly trained in the integration of expert, cost effective, and judicious application of OMT when indicated and appropriate.

Healthcare Setting Peer Review

The AOA has always fostered and encouraged peer review, both through voluntary mechanisms and, since 1972, through Federal Peer Review Programs. The AOA wishes to reaffirm its commitment to peer review regardless of federal policy or program changes. Osteopathic medicine must promote and facilitate peer review among and through its members in health care settings.

Medical Societies & Expert Witness Policies

A number of medical organizations have created programs to address the problem of inaccurate expert witness testimony.

In 1989, the American Academy of Pediatrics (AAP) created policy on appropriate expert witness testimony that includes concerns specific to pediatric cases, as well as suggestions for improving the quality of expert testimony by implementing certain requirements for expert witnesses.[5] the American Academy of Family Physicians (AAFP) supports similar requirements.[6] The American Association of Neurological Surgeons (AANS) has guidelines for expert witnesses and operates a professional conduct program under which members can be disciplined for unprofessional conduct if they violate these guidelines.[7] In 2004, the American Academy of Orthopedic Surgeons (AAOS) created an expert witness program that involves education and advocacy components.[8] The American Society of Anesthesiologists (ASA) also maintains an expert witness testimony review program under which ASA members may submit complaints against other members for violating ASA guidelines on expert testimony.[9]

In addition to the previously described medical societies, other medical organizations that track and monitor their member testimonies include the North American Spine Society and the American College of Osteopathic Obstetricians & Gynecologists (ACOOG), American College of Obstetricians and Gynecologists (ACOG). The ACOG has developed a "qualifications" documents that spells out to members the responsibilities and obligations of expert witnesses.[10] Finally, both the American College of Emergency Physicians (ACEP) and the American College of Surgeons mandate that their members submit transcripts of depositions and testimony.

Expert Testimony in the Court Room

Judges determine the admissibility of evidence, including expert testimony, based upon judicially created standards and the rules of evidence applicable to their jurisdiction. As a result, the requirements a physician must meet to qualify as an expert witness can be unclear and vary from state to state. An increasing number of states also require physicians to meet statutorily-defined requirements relating to licensure, specialization and practice activity in order to qualify as an expert witness in a medical liability case.[11]

Licensed in the State

Twenty-Four states have statutes that address the licensure required to testify as an expert witness in a medical liability case. Nearly all of these statutes simply require the physician to be

licensed to practice in one or more of the fifty states. However, Tennessee requires physician experts to be licensed in the state or a state bordering Tennessee. In addition, Florida and South Carolina require out of state experts to become certified or licensed, respectively, to qualify as an expert witness. Twenty-four states refer to or incorporate rule 702 - expert witness in their statutes. This rule defines an expert witness based on their knowledge, skill, experience, training, or education without explicitly stating that licensure is a prerequisite.

Active Practice or Teaching

Twenty-three states have statutes that require medical experts to have devoted a certain percentage of their professional time to active practice or teaching, or to have been engaged in active practice or teaching within a certain number of years. Arizona, Kansas, Michigan, New Jersey, North Carolina, Ohio and West Virginia require medical experts to have devoted at least half of their professional time to active clinical practice or teaching.

Board Certification and Specialization

Thirty-two states have statutes that address the specialization or board certification a physician must possess to testify as a medical expert. Twenty-two states require an expert to be trained and experienced in the same specialty, subspecialty, discipline or school or practice as the person the expert is testifying about. If the testimony concerns the practice of a board-certified physician in the field in which he or she is certified, twelve states require the expert to be board certified in the same or similar field as well.

Pennsylvania and South Carolina permit a medical expert to either be board certified or have professional knowledge and experience in the practice area or specialty in which the opinion is offered.

Pretrial Certificates/Affidavits of Merit

Another technique employed by states to weed out frivolous claims and unnecessary expert testimonies are “certificates of merit,” also known as “affidavits of merit.” A certificate of merit is an affidavit, signed by the plaintiff’s expert witness and attached to the original complaint, certifying that the expert witness is knowledgeable of the relevant facts of the case, is qualified to express an opinion on the merits of the case, and certifying that there is a reasonable and meritorious cause for the filing of the action. In addition, the certificate of merit officially states that the expert is qualified to make a determination of whether the defendant physician departed from the standard of care in treating the injured plaintiff. Twenty-six states currently require a physician to verify that a malpractice lawsuit has merit before it can be filed.

Other Provisions

Aside from the more traditional criteria stated above, some states adopt a broader set of expert witness qualifications. Idaho requires that expert witnesses to have knowledge of the community standards to which his or her testimony is addressed. Nevada requires expert medical testimony to be given by a provider who practices or has practiced in an area that is substantially similar to the type of practice engaged in by the defendant physician at the time of the alleged negligence. Rhode Island only requires “knowledge, skill, experience, training or education” to qualify as an expert witness. Oklahoma, and Pennsylvania permit retired physicians to serve as expert witnesses.

Some states have also clarified that a physician who provides expert testimony is engaged in the practice of medicine or is otherwise subject to discipline by the state’s licensing board for providing false, deceptive, or misleading testimony. California, Florida, Mississippi, Ohio and South Carolina have statutes that subject expert witnesses to discipline by the state’s licensing

board. In 2002, the state medical board in North Carolina ordered a physician's license to be suspended for one year due to expert testimony he provided under the theory that the physician had engaged in unprofessional conduct.

Expert Testimony in Administrative and Disciplinary Hearings

Whereas traditional courts and juries have, for the most part, adopted requirements that expert testimony be used in medical malpractice cases, professional licensing boards have responded differently. Medical licensing boards work to police the actions of physicians by establishing and enforcing the standards of medical care within their communities, frequently without the aid of expert testimony.[12] This is because in most administrative settings the judge is trier of both fact and law. Expert testimony is taken to assist the judge as the trier of fact, but it is not required.[13] In some settings, experts will testify only by deposition; whereas in others, live testimony is always needed. Additionally, it is possible that the review panel can provide opinion evidence.

Policy Behind Adopting a Requirement for Expert Testimony in Administrative Hearings

The expert testimony requirement serves three main purposes. First, expert testimony protects the defendant's right to review rather than allow a professional board to base its decision only on its own expertise.[14] Second, having expert testimony in the record makes it easier for the defendant to challenge the evidence used to support the professional board's claim.[15] Finally, many courts recognize that members of a professional board are not necessarily qualified to make a medical opinion, and do not want to put a defendant's license at risk under those circumstances. However, most jurisdictions, even those who require expert testimony, often can decide when to apply the requirement. Consequently, states have a tendency to modify or soften their rules concerning the admission of expert testimony in administrative hearings.[16]

Compensation and Disclosure Requirements

In addition to peer review and strengthened expert witness qualifications, the unregulated compensation an expert witness may charge for medical testimony has contributed to the "hired gun" perception. Exorbitant compensation for expert witness testimony dilutes the integrity of the medical profession by creating the perception that these witnesses have an incentive to tailor their testimonies to the needs of the attorneys who pay them. [17] This perception is exacerbated by the practice of making the payment of an expert witness's fee contingent upon the outcome of the case. In most jurisdictions, the common law rule forbade paying expert witnesses a contingent fee.[18] Arizona, Florida, Michigan, New Hampshire, New Jersey, North Carolina, and Wisconsin now have statutes that prohibit paying expert witnesses on a contingency basis or make expert testimony provided according to a contingent fee arrangement inadmissible.

AOA Policy statements

Appropriate standards are necessary to govern the use of expert testimony and peer review. The following statements represent the AOA's position on appropriate use of expert witness testimony and peer review:

The AOA believes that based on the Daubert decision, a trial court must determine if the opinion of the expert is reliable. In making that determination, the trial court may consider: (1) whether the theory or technique has been or can be tested; (2) whether the theory or technique has been proven by the peer review process or published within the scientific community; (3) the known rate of error, or the potential rate of error; (4) whether standards exist in the particular field or science from which the expertise comes; and (5) whether the theory or technique that is the subject of the opinion or testimony has been generally accepted by the particular scientific community;

The AOA finds that as a result of the Daubert decision, the medical community has developed guidelines for evidence-based medicine. Evidence-based medicine may be authenticated by three sources: (1) large, controlled, randomized clinical trials; (2) observational scientific studies; and (3) consensus recommendations from a panel of recognized experts in the clinical or research field;[19]

The AOA affirms its commitment to promote and facilitate peer review among and through its members;

The AOA supports a policy that peer review of osteopathic physicians should be conducted by other osteopathic physicians, whenever possible, to account for osteopathic physicians' unique training in Osteopathic Principles and Practices and OMT;

The AOA believes that when the standard of care involves a procedure unique to the osteopathic practice of medicine, such as OMT, then only osteopathic physicians should conduct peer review of DOs;

The AOA pledges to pursue any and all legal and legislative recourses to assure that insurance claims reviewed by peers regarding the provision of OMT procedures may only be conducted by qualified osteopathic physicians;

The AOA believes that the voluntary hospital peer review process remains the most natural and appropriate vehicle through which to effect institutional peer review;

The AOA believes that all peer review should remain confidential and undiscoverable except to the physician who is the subject of the peer review;

The AOA believes that all review under the peer review organization program of osteopathic diagnosis and therapeutics be performed by osteopathic physicians.

The AOA believes that an osteopathic physician's failure to provide truthful testimony or peer review constitutes unprofessional conduct subject to peer review consistent with the AOA's policy that expert testimony and peer review by osteopathic physicians constitute the practice of medicine;

The AOA encourages state divisional societies to develop and implement appropriate procedures and measures to monitor and discipline member expert witnesses who provide fraudulent and misleading testimony;

The AOA pledges to support any osteopathic society that wishes to develop its own program to discipline physicians for unprofessional conduct related to expert witness testimony;

The AOA pledges to act as a clearinghouse for advice on the issue of expert witness testimony;

The AOA supports updating state licensing laws to include "providing false or misleading information in the role of expert witness" in the definition of unprofessional conduct;

The AOA's believes that an expert witness should not provide medical testimony that is false, misleading, or without medical foundation;

The AOA's believes that an expert witness should have a current, unrestricted license to practice in the same state as the defendant physician. Preferably, the expert witness should be board certified in the same medical specialty as the defendant and the certifying board should be one that is recognized by the state;

The AOA's believes that an expert witness should be three (3) years removed from residency training and should be engaged in active medical practice or have teaching experience, or any combination thereof in the same specialty or subspecialty, for a period of no less than three (3) years prior to the date of the testimony. In cases where the physician serving as an expert witness has completed a forensic science, pediatric child abuse, or other approved forensic fellowship and where the expert testimony specifically relates to that training, the requirement of being three (3) years removed from residency training is waived;

The AOA encourages state licensing boards to grant temporary licensure to out-of-state expert witnesses upon a showing of the inability to find an in-state expert witness to make them subject to disciplinary sanctions of the state licensing boards;

The AOA opposes allowing expert witnesses to accept compensation that is contingent on the outcome of the case;

The AOA believes that an expert witness' compensation must be proportionate to the time, level of expertise, and effort given for preparing and attending court appearances; and

The AOA supports a policy that imposes mandatory disclosure to the court and opposing parties of the qualifications of the expert witness, access to copies of all publications authored by the witness in the preceding ten (10) years, and access to transcripts from all cases in which the witness has testified as an expert witness in the preceding four (4) years.

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13 Timothy P. McCormack, Expert Testimony and Professional Licensing Boards: What is Good, What is Necessary, and the Myth of the Majority-Minority Split, 53 Me. L. Rev. 139, 144 (2001).

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15 McCormack, supra note 23 at 147

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19 27 NCAC2.3, rule 3.4, comment 3.

Source: H337-A/23

Status: 2008, 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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Payors – Osteopathic Discrimination by

Policy Statement

The American Osteopathic Association (AOA) is opposed to discrimination against osteopathic physicians by payors and urges that federal and state legislation must clearly state that any and all payors must accept as sufficient professional credentials all licenses properly granted by state boards of medicine or osteopathic medicine, and all specialty certifications granted by boards approved by the AOA or American Board of Medical Specialties.

Source: H338-A/23

Status: 1993; 1998 Reaffirmed as Amended, 2003; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended; 2023 Adopted

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Special Licensing Pathways for Physicians-Opposition to

Policy Statement

The American Osteopathic Association (AOA) opposes the creation of special licensing pathways which allow physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education (ACGME) accredited training program ("residency"), or who have not completed at least one year of post-graduate U.S. medical education accredited by the ACGME, to practice medicine under limited supervision by a fully trained and licensed physician.

Source: H339-A/23

Status: 2018; 2023 Adopted as Amended

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Uniform Emergency Volunteer Health Practitioners Act (UEVHP)

Policy Statement

The American Osteopathic Association (AOA) supports enactment of the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) with amendments to include DOs wherever MDs are listed.

Source: H340-A/23

Status: 2008; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted as Amended

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Timely Posting of Meeting Agendas/Materials and Approval of Meeting Minutes

Policy Statement

Agendas and meeting materials for American Osteopathic Association (AOA) meetings will be sent to committee members and posted to a dedicated webpage on the AOA website at least ten (10) business days prior to the respective meeting. The minutes from AOA meetings will be submitted to the respective committee members for review and comment no later than ten (10) business days following the conclusion of the meeting. Committee members shall then review and provide feedback for AOA staff to incorporate and submit to the committee chair and/or vice chair within ten (10) business days. The committee chair and/or vice chair shall then have ten (10) business days to review and approve any revisions.

AOA staff shall then distribute revised minutes to committee members within ten (10) business days of their approval by the committee chair and/or vice chair, and then they shall be posted to a dedicated website accessible to members no later than ten (10) business days following final approval.

Meeting materials containing sensitive or confidential information may be redacted with the authorization of the appropriate bureau or committee chair and AOA legal counsel prior to being placed on the public website but shall never be redacted in the official minutes of record. No bureau or committee recommendations may be considered by any other AOA body until the minutes of the meeting have been finally approved. Note: “appropriate members” will be defined as members of the bureau, committee or board at the time the meeting was held; and that AOA staff leadership be held accountable by the AOA Board of Trustees for immediately, appropriately and consistently implementing this policy to promote organizational transparency and protect AOA volunteers in the performance of their fiduciary duties.

Source: H341-A/23

Status: 2018; 2023 Adopted

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Sunset Resolutions

Policy Statement

The American Osteopathic Association (AOA) reviews policy every five years to either reaffirm, reaffirm with amendments or sunset the policy. A thorough explanatory statement as to the reason supporting the decision should be provided. Policies under sunset review will receive a new resolution number pertinent to the year of review. If approved by the House of Delegates, the resolution number provided during the year of review will become the new policy number. The source code listed within the title will reflect the current policy number under review.

Source: H342-A/23

Status: 2018; 2023 Adopted as Amended

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Workplace Violence Against Healthcare Providers

Policy Statement

The American Osteopathic Association (AOA) affirms the position that acts of violence against physicians, learners, staff and healthcare workers should be prosecuted criminally as a felony across all states, territories, provinces, where osteopathic physicians practice.

The AOA supports legislation in line with the position that acts of violence against physicians, learners, staff and healthcare workers should be prosecuted criminally as a felony across all jurisdictions where osteopathic physicians practice.

The AOA will oppose stigmatizing physicians, learners, staff and healthcare workers who speak out against workplace violence in the healthcare environment.

The AOA acknowledge that the threat against physician well being, in the form of workplace violence, is a threat against the healthcare system, and therefore society as a whole.

Source: H343-A/23

Status: 2023

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AOA Support for GME Equity

Policy Statement

The American Osteopathic Association (AOA) supports non-legislative, properly vetted legislative and regulatory and other public policy solutions that assure GME equity for osteopathic medical students and also assure universal acceptance of applications from qualified osteopathic medical students and universal acceptance of COMLEX when a test score is required by a GME program.

The AOA Board of Trustees to report back semi-annually to the members beginning with the Midyear meeting on the progress that has been made to assure equity exists for osteopathic graduates to enter residency programs in all fields of medicine and surgery.

Source: H345-A/23

Status: 2023

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Non-AOA Member CME Services and Activity Fee

Policy Statement

The American Osteopathic Association (AOA) will have the annual non-AOA member CME services and activity fee be an amount determined by the AOA Board of Trustees starting in 2024. The annual non-AOA member CME services and activity fee will be waived for regular AOA members. The annual non-AOA member CME services and activity fee will be part of the CME Portal subscription fee. All AOA diplomates will have access to self-report their CME activities.

Source: H346-A/23

Status: 2023

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Advocate Congress to Close the Title IV Loophole that has been used to Enable Funds to Cover the Cost of Attendance at For Profit Medical Schools that would otherwise be Ineligible

Policy Statement

The American Osteopathic Association (AOA) will work with the American Medical Association (AMA) and other interested stakeholders to advocate for congressional oversight of the misuse of Title IV funding by for-profit offshore medical schools (which would otherwise be ineligible for such funding) through any partnership, affiliation or other type of arrangement with a Title IV-eligible institution. The oversight would expressly prohibit and prevent the use of funds granted in an application to be used for any purposes, including but not limited to tuition, transportation, or cost of attendance at an institution not identified in the primary application.

Source: H347-A/23

Status: 2023

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Drug Formularies

Policy Statement

The American Osteopathic Association (AOA) supports policies that ensure drug formularies offer robust coverage of treatment options across therapeutic areas, and policies that ensure plans provide an expeditious appeal process with a further peer to peer review option.

Source: H300-A/24

Status: 1999; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed as Amended 2014; 2019 Reaffirmed; 2024 Adopted as Amended

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Importation of Medications

Policy Statement

The American Osteopathic Association (AOA) supports the importation of medications that may be imported under the authority of the U.S. Food and Drug Administration and encourages its members to assist patients in utilizing the many programs that are available to provide patients with free or reduced-cost medications.

Source: H301-A/24

Status: 2004; Reaffirmed 2009; 2014; Reaffirmed 2019; 2024 Adopted

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Maternal Mortality

Policy Statement

The American Osteopathic Association (AOA) supports:

1.The important work of maternal mortality review committees

2.The work with state and relevant specialty medical societies to advocate for state and federal legislation to establish and maintain Maternal Mortality Review Committees

3.The work with state and relevant specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees.

Source: H302-A/24

Status: 2019 Reaffirmed as Amended; 2024 Adopted

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Extending Medicaid to 12 Months Postpartum

Policy Statement

The American Osteopathic Association (AOA) supports state and federal policy to extend Medicaid coverage to 12-months postpartum.

Source: H303-A/24

Status: 2019; 2024 Adopted as Amended

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Hospital Consolidation – Opposition to

Policy Statement

The American Osteopathic Association (AOA) opposes further consolidations of hospitals and health systems that:

1. Lack sufficient evidence of and commitment benefit to patients' access to quality and affordable care

2. Limit physicians' ability to negotiate equitable relationships with hospitals and payors due to disproportionate market control

3. Distort market dynamics in a manner that discourages competition and patient choice.

Source: H304-A/24

Status: 2019 Reaffirm as Amended; 2024 Adopted as Amended

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Misaligned Incentives in Medicare Plans

Policy Statement

The American Osteopathic Association (AOA) support efforts to align patient's behaviors with cost-effective, reportable high quality care.

The AOA will work to identify these misaligned incentives, and advocate for changes to the Medicare program that support physicians in delivering high-value care and discourage plans from preventing patients from seeking lower cost-effective treatment options.

The AOA will advocate against misaligned payment and quality incentives in Federal Healthcare programs that do not promote improved health outcomes; and, that the AOA works to educate the NCQA regarding the need to modify Healthcare Effectiveness Data and Information Set (HEDIS) rules.

Source: H305-A/24

Status: 2019 Reaffirm as Amended; 2024 Adopted as Amended

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Opposing Targeted Regulation of Abortion Providers (Trap Laws)

Policy Statement

The American Osteopathic Association (AOA) oppose the Targeted Regulation of Abortion Providers (TRAP laws) that impede and discriminate against a physician's ability to provide appropriate care to patients seeking comprehensive reproductive health services, including abortion.

Source: H306-A/24

Status: 2019; 2024 Adopted as Amended

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Physically Active Video Games – (Exergaming Health) Benefits

Policy Statement

The American Osteopathic Association (AOA) encourages osteopathic physicians to increase their awareness of the potential benefits of exergaming and include exergaming as a component of a person's exercise program or when situational circumstances prohibit other types of exercise.

Source: H307-A/24

Status: 2009; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Adopted as Amended

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Cardiovascular Disease and Women

Policy Statement

The American Osteopathic Association (AOA):

1.Encourages its members to participate in continuing medical education programs on cardiovascular disease (CVD) in women

2.Urges osteopathic state and specialty associations to offer CME on CVD in women, as part of their educational offerings

3.Encourages its members to participate in national initiatives on women's health

4.Will continue to recognize national women's health week and national women's check-up day

5.Encourages appropriately designed studies on contributors to CVD in women

6. Encourage lawmakers to enhance funding for female cardiovascular risk reduction and education

Source: H308-A/24

Status: 2004; 2009; Reaffirmed as Amended 2014; 2019 Reaffirmed as Amended; 2024 Adopted as Amended

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Healthy Weight for Families

Policy Statement

The American Osteopathic Association (AOA) encourages participation of its members in personal health promotion.

The AOA encourages osteopathic medical schools to incorporate personal health promotion as a part of their graded curriculum; supports participation of its members in outreach efforts to engage with local school districts in order to develop and improve wellness policy interventions to reduce childhood obesity.

The AOA encourages state and specialty associations to collaborate with local school districts and major local employers to enhance wellness policy development, implementation, data assessment and improvements.

The AOA encourages its members to participate in national and local initiatives on obesity.

Source: H309-A/24

Status: 2004; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Adopted as Amended

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Abuse of Performance Enhancing Substances and Procedures

Policy Statement

The American Osteopathic Association (AOA):

1. Supports efforts to eliminate the abuse of performance enhancing substances, for the purpose of enhancing athletic performance or physical appearance

2. Supports the efforts of appropriate national and international regulatory bodies to protect clean athletes and ensure their rights to compete on a fair and level playing field, free from the pressures of performance enhancing drugs

3. Supports the education of athletes, the public and physicians of the dangers of these substances.

Source: H311-A/24

Status: 1989; 1994 Reaffirmed as Amended; 1999 Reaffirmed; 2004 Reaffirmed as Amended; 2009 Reaffirmed as Amended; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Adopted as Amended

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Tobacco Use Status – Reporting in the Medical Record

Policy Statement

The American Osteopathic Association (AOA) supports the U.S. Preventive Services Task Force (USPSTF) guideline on tobacco use cessation that specifically recommends identifying tobacco use status on each patient visit to increase the likelihood of physician intervention with their patients who use tobacco.

Source: H312-A/24

Status: 1999; 2004 Reaffirmed as Amended; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted

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Testosterone Therapy: Long Term Effect on Health

Policy Statement

The American Osteopathic Association (AOA) supports ongoing funding and independent research on the long-term risk/benefits of testosterone therapy.

Source: H313-A/24

Status: 2014; 2019 Reaffirmed; 2024 Adopted as Amended

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Home-Based Care for Frail Persons

Policy Statement

The American Osteopathic Association (AOA) supports the development of programs, that provide appropriate access to healthcare services including home-based care for the frail patient population.

Source: H314-A/24

Status: 1999; 2004 Reaffirmed as Amended; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Adopted as Amended

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Health Care Costs in Long Term Services and Support

Policy Statement

The American Osteopathic Association (AOA) supports to the development and implementation of programs that improve long-term services and support and ensure the delivery of quality care.

Source: H315-A/24

Status: 1984; Revised 1989; Reaffirmed 1994; Revised 1999; Reaffirmed 2004; Reaffirmed as Amended 2009; Reaffirmed as Amended 2014; Reaffirmed as Amended 2019; 2024 Adopted as Amended

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Human Cloning

Policy Statement

White Paper – Human Cloning

The American Osteopathic Association has adopted the following white paper:

BACKGROUND

Somatic cell nuclear transfer (SCNT) or, to use the more common vernacular, cloning is the process of creating genetic duplication of a cell or an organism naturally or artificially.[1,2,3] The National Institute of Health (NIH) describes "cloning" as a process "that can be used to produce genetically identical copies of a biological entity".[4] More specifically, the National Human Genome Research Institute (NHGRI) of NIH, identifies three categories of artificial cloning: gene, reproductive and therapeutic. The latter two types of cloning are often lumped together as "human cloning," which is controversial and the focus of much debate.

TYPES OF CLONING

Gene Cloning

Gene cloning (also known as DNA cloning or molecular cloning) is the process wherein genes or segments of DNA are copied. DNA cloning is beneficial to medicine because the technology allows doctors to treat patients by replacing flawed genes associated with inherited diseases with healthy ones. Gene cloning is primarily seen in genetically engineered food and in animals to help them grow stronger. This type of cloning does not have the possibility of creating an adult living creature.

Reproductive Cloning

Reproductive cloning is the process of using SCNT to obtain eggs that could develop into an adult living creature. The mature somatic cell is transferred into another egg cell and allowed to develop into an embryo in a test-tube and then implanted into the womb of a living creature. The hope is that the outcome will be a birth with the same genetic makeup as the living creature from which the mature somatic cell was taken.

Reproductive cloning experimentation has been occurring for many decades but has primarily focused on animals as opposed to human beings. In 1979, mice were cloned by splitting mouse embryos. In 1996, the lamb, Dolly was successfully cloned. In 1998, several calves were cloned. Another notable cloning of a mammal was in 2003, when an endangered ox, Banteg, was cloned. A recent announcement was made in January 2024 of the successful cloning of a rhesus monkey in China in 2020.5 While there have been a few successfully cloned mammals, there have been no verified successful attempts to clone a human embryo/being.

Therapeutic (Research) Cloning

Therapeutic cloning is the process of creating a cloned embryo in an effort to produce embryonic stem cells to help understand the epidemiology of diseases and to develop new treatments.[4,6] Therapeutic cloning involves some of the same techniques used in reproductive

cloning. However, the stem cells are harvested from the embryo during the test tube phase, therein destroying the embryo.

ARGUMENTS FOR OR AGAINST CLONING

In the United States and worldwide, cloning remains a moral and ethical point of consternation. There are arguments both for and against the use of cloning, but there appears to be a consensus amongst many that cloning an actual human being is not acceptable.[6,7,8] Therapeutic cloning is often the center of most debates for many regarding balancing patient care, morals and ethics.

Arguments against therapeutic and reproductive cloning[8]:

- Reproductive and therapeutic cloning leads to the destruction of human embryos which many see as viable human life.
- Reproductive cloning usurps the divine plan or interferes with the natural order.
- Cloning violates human dignity and treats human beings as commodities or items to be manufactured.
- Cloning causes risks to human health; the majority of implanted embryos die in gestation or result in births with significant abnormalities. In addition, the need for human embryos may cause women in poverty to compromise health due to incentives to sell embryos.

Arguments for therapeutic and reproductive cloning[8]:

- Reproductive and therapeutic cloning presents a unique ability to research and identify treatments to address human diseases by providing insight to researchers on developmental and pathogenic events not discoverable otherwise.
- Cloning may lead to alleviation of human suffering and cures for costly and debilitating diseases by providing genetically matched tissue for transplantation.
- Cloning promotes scientific inquiry.

LEGISLATION IN THE U.S. ON CLONING

Currently, the federal government does not explicitly prohibit cloning. However, the government does prohibit the use of federal funds for cloning, regardless of the purpose (therapeutic or reproductive cloning).[8,9,10] The NIH primarily conducts gene cloning. NIH relies on federal funding which is prohibited from being used in therapeutic or reproductive cloning activities, and accordingly, NIH researchers have not cloned any mammals nor have any of the institutions or centers supported human cloning activities.

The Food and Drug Administration (FDA) has weighed in on human reproductive cloning. In a 1998 letter about human cloning, the FDA claimed jurisdiction over clinical research using cloning technology for reproductive purposes. The FDA equated using cloning technology to the same process as developing new drugs.[11] In a second letter dated March 28, 2001, regarding Cloning Technology, the agency reiterated its jurisdiction over clinical research using such technology. The FDA explicitly stated that the process is subject to the Health Service Act and the Federal Food, Drug and Cosmetic Act. also indicated that all approval responsibilities for any human clinical use of any therapies derived from cloning research fell within its purview.[12]

In an effort to address the void left by the federal government, several state legislatures have provided guidance on human cloning.[9]
research as well as to implant in a uterus for childbirth) – Arizona, Arkansas, Indiana, North Dakota, Oklahoma, South Dakota and Virginia

- **Eight (8) states** prohibit human cloning for any purpose – no reproductive or therapeutic cloning (cloned human embryos for embryonic stem cell research as well as to implant in a uterus for childbirth) – Arizona, Arkansas, Indiana, North Dakota, Oklahoma, South Dakota and Virginia

- **Six (6) states** prohibit state funding of human cloning for any purpose – Arizona, Arkansas, Indiana, Louisiana, Maine and Nebraska

- **Ten (10) states** have "clone and kill" laws which allow therapeutic cloning research, but prohibit cloning of embryos to be implanted for childbirth (reproductive cloning) – California, Connecticut, Illinois, Iowa, Maryland, Massachusetts, Missouri, Montana, New Jersey and Rhode Island

- **Five (5) states** allow state funding for embryonic stem cell research (therapeutic cloning or in vitro fertilization) – California, Illinois, Missouri, Maryland and New York

- **Two (2) states** have legislation that precludes health professionals from being compelled to participate in human cloning (healthcare rights of conscience laws) – Idaho and Louisiana

Twenty-six (26) states and the District of Columbia do not have any legislation addressing therapeutic (biomedical research) and/or reproductive (to produce children) cloning.
Since 2019 there has been little legislation activity at the state and federal level.

KEY ORGANIZATIONS SUPPORTING THERAPEUTIC/RESEARCH CLONING
Many key organizations have made position statements regarding the benefits it views in therapeutic cloning and accordingly expressed their support. In addition, these organizations have declined to support cloning for reproductive purposes. These organizations include:

American Association for the Advancement of Science (AAAS) – The AAAS has a statement on Human Cloning that states it endorses a legally enforceable ban on efforts to implant a human cloned embryo for the purpose of reproduction.[11] AAAS recognizes that the health risks associated with reproductive cloning make such cloning unconscionable. The AAAS, however, does encourage continued dialogue as new technological advances emerge.

Also, AAAS supports stem cell research (genetic and therapeutic cloning) which has potential health benefits. The AAAS calls for strict monitoring of the process and developments and appropriate oversight through regulation. [11]

American Medical Association (AMA) - The AMA does not endorse reproductive cloning. However, if in the future reproductive cloning is permitted, the AMA acknowledges that physicians must be educated and understand somatic cell donors must provide informed consent. Additionally, any child produced through reproductive cloning is recognized as a human-being. Code of Medical Ethics Opinion [4.2.6.15]

The AMA says physicians can determine whether they will participate in stem cell research or use its products. The AMA implores clinician researchers to be able to articulate the risks and benefits of embryonic stem cell use for research purposes. In addition, AMA encourages physicians to allow their commitment to the welfare of patients to guide them in their professional standards. Code of Medical Ethics Opinion [7.3.8.16]

National Academies of Medicine, Sciences and Engineering (National Academies) - The National Academies, based on recommendations generated by 2002 joint panel, recommends a legally enforceable ban on the practice of human reproductive cloning, but does support using SCNT to produce stem cells for developing new medical therapies for life-threatening diseases and advancing knowledge.[17]

AOA AND HUMAN CLONING

The osteopathic community and the AOA have discussed this issue at length since 1998. Recognizing the moral and ethical dilemmas of human cloning, AOA has continued to monitor the issue and provide updates to its constituents in order to facilitate a discussion.

After reviewing the existing literature on cloning, the American Osteopathic Association (AOA) adopts the following policies:

1. The AOA does not endorse the practice of human cloning for purposes of reproduction (efforts to implant a human cloned embryo for the purpose of reproduction).
2. The AOA recognizes the benefits and harms of human cloning for therapeutic (research) purposes with respect to embryos, donors and patients suffering from debilitating and life-threatening diseases and conditions. Physicians shall have the autonomy to determine whether or not they will participate in therapeutic cloning. They should carefully weigh all ethical and moral aspects of the process and determine what is best for the well-being of patients, society as a whole, and the advancement of medical knowledge and practice.
3. The AOA shall review its policy in light of any new evidence that will be generated by research entities as well as monitor state and federal legislation in the field and update the policy as necessary.

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Source: H316-A/24

Status: 2019; 2024 Adopted as Amended

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White Papers – Updating

Policy Statement

The American Osteopathic Association (AOA) will incorporate the following practices when updating White Papers:

When policies which are or include a “white paper” as a part of the policy are reviewed as part of the regular policy review process, the reviewing entity shall review and update all statistics, studies, and other data to ensure that these references are the most up-to-date statistics, studies, and data that are available.

The reviewing entity shall affirm in an explanatory statement that all statistics, studies, and other data have been reviewed and are the most current available.

Source: H317-A/24

Status: 2019 Reaffirmed; 2024 Adopted

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Direct-to-Consumer Marketing of Health Screening and Testing

Policy Statement

The American Osteopathic Association (AOA) is against direct-to-consumer marketing of medical tests and exams that may be unnecessary and encourages its members to educate their patients about which services are appropriate based on U.S. Preventive Services Task Force recommendations and other nationally recognized clinical practice guidelines.

Source: H318-A/24

Status: 2009; 2014 Reaffirmed; 2019 Reaffirmed as Amended; 2024 Adopted

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Newborn HIV Testing

Policy Statement

The American Osteopathic Association (AOA) recommends HIV testing immediately with expeditious reporting of results of newborns whose mothers' HIV status is unknown and where clinically indicated.

Source: H319-A/24

Status: 2003; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Adopted

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Influenza Immunization for Health Care Workers and Educators

Policy Statement

The American Osteopathic Association (AOA) strongly supports and recommends influenza vaccinations for all health care workers and educators according to current guidelines of the Centers for Disease Control and Prevention (CDCP).

Source: H320-A/24

Status: 2009; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Adopted

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Flu Pandemic – Osteopathic Treatment of

Policy Statement

The American Osteopathic Association (AOA) supports the active utilization of Osteopathic Manipulative Treatment (OMT), along with other recognized and approved medical interventions, in the treatment of flu pandemics and other infectious outbreaks; and will conduct programs to disseminate appropriate training in OMT.

Source: H321-A/24

Status: 2009; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Adopted

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Osteopathic Manipulative Treatment (OMT) of the Cervical Spine

Policy Statement

The American Osteopathic Association, in the hopes of advancing the science of osteopathic medicine adopts the following position:

> These recommendations are provided for osteopathic educators and physicians making decisions regarding the instruction of cervical spinal manipulation and the care of patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by a patient's physician. Like all reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the understanding that continued research is needed.

AMERICAN OSTEOPATHIC ASSOCIATION OSTEOPATHIC MANIPULATIVE TREATMENT OF THE CERVICAL SPINE

Background and Statement of Issue

Treating chronic pain continues to be an important health issue for osteopathic physicians. Globally, in 2020, neck pain affected 203 million people.[1] As of 2016low back and neck pain had the highest amount of health care spending in the U.S with an estimated $134.5 billion in spending.[1] Back and neck pain are two leading causes of chronic pain and they are amongst the leading causes of people living with disabilities in the United States (U.S.) as well as worldwide. More specifically, back and neck pain are ranked in the top 8 diseases and injuries in the U.S. regarding years lived with disability (YLDs) and in the top 6 globally.[2,3] Cervical spine manipulation is one option for treating back and neck pain.
Concerns continue to arise regarding the safety of cervical spine manipulation. Specifically, concerns center on the potential development of serious adverse events such as stroke and cervical artery dissection after spinal manipulation. Since spinal manipulation is an option available to osteopathic physicians to incorporate into the care of their patients, it is important to examine these concerns and develop a position on the issue. This paper will present the evidence behind the benefit of cervical spine manipulation, explore the potential harms, and make a recommendation about its use.

Benefit

Spinal manipulation has been reviewed in various systematic reviews and meta-analyses over the past three decades. The majority of the studies conducted on spinal manipulation focus on low back pain for which the evidence has shown spinal manipulation has clear benefits.[4-8] For neck pain, however, there are fewer studies and the findings vary, but there is evidence concluding that spinal manipulation benefits patients who present with neck pain.[9-14] This evidence indicates that the benefits of spinal manipulation include relief of acute neck pain, and reduction in neck pain as measured by validated instruments in sub-acute and chronic neck

pain compared with muscle relaxants or usual medical care.[14-18] Bronfort et al specifically concluded that for patients with chronic neck pain, there is moderate evidence that (1) manipulation and mobilization are superior to general practitioner management in the short term, (2) high-technology exercise results in more pain improvement than manipulation in the long term for a mix of patients with acute and chronic pain, and (3) mobilization is superior to physical therapy and general medical care and similar to manipulation in both the short and long term.[16]

Benefits of spinal manipulation for areas beyond the low back and neck include short-term relief from tension-type headaches, temporomandibular joint disorders and shoulder pain.[8,15,19] Additionally, manipulation for cervicogenic headache ~~and~~ is comparable to commonly used first line preventative prescription medications for tension-type headache and migraine.[16]

Risk

The literature presents varying conclusions on the harms of spinal manipulative treatment (SMT).[6,7] In a 2017 review of risks associated with spinal manipulation, 46% percent of the studies reviewed found spinal manipulation to be safe, 42% percent were neutral (did not find harm/benefit); and the remaining 12% percent concluded that spinal manipulation was unsafe because of the possibility of serious adverse events.[7] Nevertheless, the existence of any adverse effect should not be trivialized.

Studies have noted that there are two types of adverse effects as a result of SMT. The first type are considered mild adverse events that are short-term and non-serious such as dizziness, fatigue, and muscle soreness/ discomfort.[7,20] When present these side effects occur in 23-83% of patients. The second type of adverse events is more serious and includes cervical artery dissection, stroke, spinal cord injuries, and other serious conditions outcomes related to vertebrobasilar accidents (VBAs). Currently, much of the literature discusses vertebrobasilar insufficiency or vertebrobasilar ischemia (VBI) which is a type of VBA and is often determined to be the link to the more serious adverse events. Nonetheless, serious adverse events are seen as a rarity, and it is estimated that they occur in the range of one in every 20,000 to 250,000,000 manipulations performed.[7,13,20-28]

Most of the reported cases of adverse outcomes have involved thrust or High Velocity/Low Amplitude (HVLA) types of manipulative treatment.[20,26] Unfortunately, many of the reported cases do not distinguish the type of manipulative treatment provided.

VERTEBROBASILAR ACCIDENTS

Vertebrobasilar accidents (VBA) account for 1.3 in 1000 cases of stroke, making them a rare event. Approximately 5% of patients with a VBA die as a result, while 75% have a good functional recovery.[29] The most common risk factors for VBAs are migraine, hypertension, oral contraceptive use and smoking.[30] Elevated homocysteine levels, which have been implicated in cardiovascular disease, may be a risk factor for a VBA.[31] The more risk factors that an individual has, the more likely they are to sustain a VBA.[32]

The risk of a VBA occurring spontaneously, is nearly twice the risk of a VBA resulting from cervical spine manipulation.15 A study done in 1999 reviewing 367 cases of VBA reported from 1966-1993 showed 115 cases related to cervical spine manipulation; 167 were spontaneous, 58 from trivial trauma and 37 from major trauma.[33]

A study in 2002 conducted by Haldeman et al., reported that a VBA following cervical spine manipulation was unpredictable.[25] The authors, however, concluded that a VBA following cervical spine manipulation was “idiosyncratic and rare”. Further review of the data showed that 25% of the cases presented with sudden onset of new and unusual headache and neck pain often associated with other neurologic symptoms that may have represented a dissection in progress.[34]

Complications from cervical spine manipulation most often occur in patients who have had prior manipulation uneventfully and without obvious risk factors for a VBA.[15] “Most vertebrobasilar artery dissections occur in the absence of cervical manipulation, either spontaneously or after trivial trauma or common daily movements of the neck, such as backing out of the driveway, painting the ceiling, playing tennis, sneezing, or engaging in yoga exercises.”25 In some cases manipulation may not be the primary culprit for causing the dissection, but an aggravating factor or coincidental event.[34]

It has been proposed that thrust techniques that use a combination of hyperextension, rotation and traction of the upper cervical spine will place the patient at greatest risk of injuring the vertebral artery. In a retrospective review of 64 medical legal cases, information on the type of manipulation was available in 39 (61%) of the cases. Fifty-one percent (51%) involved rotation, with the remaining 49% representing a variety of positions including lateral flexion, traction and isolated cases of non-force or neutral position thrusts. Only 15% reported any form of extension.[34]

Cervical Artery Dissection (CAD)

CAD occurs at a rate of 2.9 per 100,000 individuals every year in the general population, and a large majority (89%) of the individuals diagnosed with CAD have no symptoms or no significant disability that prohibits them from being productive within the following three months of the event.[32] Among those with symptoms, headaches and neck pain are the predominant symptoms for CAD. This creates a dilemma for physicians because cervical spine manipulation is often sought to treat these medical issues. Thus, it is difficult to determine if manipulation causes CAD or if CAD existed at the time of treatment.

Limitations of Studies and Concerns with Pre-manipulation Screening

Due to the design of studies (case reports or retrospective surveys), infrequent reporting of adverse events, and the rare occurrence of many of the more serious complications, it is difficult to determine a causal relationship between SMT and the serious adverse effect.[7,32] Thus the lingering question of whether or not pre-existing pathologies may have existed prior to the patient receiving SMT remains.[20,27,35]

In Malone et al., the authors reported that cervical spine manipulation may worsen preexisting cervical disc herniation or even cause cervical disc herniation.[27] This report describes complications such as radiculopathy, myelopathy, and vertebral artery compression by a lateral cervical disc herniation. The incidence of these types of complications could be lessened by rigorous adherence to published exclusion criteria for cervical spine manipulation.[27,36]
Another noteworthy point to highlight is that the literature does not clearly distinguish the type of provider (i.e. M.D., D.O., D.C. or P.T.) or manipulative treatment (manipulation vs. mobilization) provided in cases associated with serious adverse effects. This information may help to understand the mechanism of injury leading to serious adverse effects, as there are differences

in education and practice among the various professions that utilize this type of treatment. It is duly noted that the osteopathic approach strictly limits the “thrust”, which is more commonly referred to as “impulse” in osteopathic practicums, to the physiologic barrier as opposed to the chiropractic approach may extend to the paraphysiologic space.

Additionally, pre-manipulation screening tools, that might be used to identify a patient’s risk for VBA and cervical artery dissection have been widely criticized because they have been found to be unreliable and difficult to validate.[29,30,37-44] These studies have examined the Wallenberg and DeKleyn’s test and others like it and determined the tests are unreliable for demonstrating reproducibility of ischemia or risk of injuring the vertebral artery.[37-45] There is acknowledgement that further research should be completed to assess the reliability of these tests for validity.[45] For this reason, researchers and groups such as the Bone and Joint Decade Task Force on Neck Pain and Its Associated Disorders recommend that all health care providers conduct a thorough patient history, physical examination and patient self-assessment to rule out certain pre-existing conditions.[14,46]

Alternative Treatments

Pharmacologic

Non-steroidal anti-inflammatory drugs (NSAIDs)

NSAIDS such as ibuprofen and aspirin are the first line medications for neck pain. More than 30 million people worldwide use NSAIDs regularly.[47] In fact, 5% of all medical visit outcomes in the U.S. include a prescription for NSAIDS.[48] NSAIDs offer temporary relief, but long-term use, gender, age, strength of dose as well as consumption of multiple medications simultaneously may be associated with serious risks affecting the gastrointestinal (GI), renal and cardiovascular systems.[49,50] Eighty-one percent (81%) of GI bleeds related to NSAID use occur without prior symptoms.[51] Research in the United Kingdom has shown NSAIDs will cause 12,000 emergency admissions and 2,500 deaths per year due to GI tract complications.[31] The annual cost of GI tract complications in the U.S. is estimated at $3.9 billion, with up to 103,000 hospitalizations and at least 16,500 deaths per year therein making GI toxicity from NSAIDs the 15th most common cause of death in the United States.[51-53] Second line pharmacologic intervention includes the use of a short course of muscle relaxers such as cyclobenzaprine or tizanidine.[54] Nervous system interactions including sedation and dizziness may be associated with the use of these medications. Additionally, there are many drug-drug interactions and hepatic/renal function should be considered when prescribing.[55]

Interventional

Trigger points are defined as “discrete, focal, hyperirritable spots” which are often treated with the use of point injections (TPIs). The literature indicates that the use of trigger point injections is associated with decreased subjective pain intensity and improved range of motion for neck pain sufferers. Often local anesthetic medications are used for TPIs which are composed of one long and one short acting anesthetic. Trigger point injections are not intended for long term use. Some of the immediate complications include vasovagal syncope, infection at the injection site, pneumothorax, needle breakage, hematoma formation and damage to surrounding structures.[56] More serious complications include accidental intravascular injection of the TPI which have a theoretical risk of cardiovascular and neurotoxicity. Nerve blocks have an incidence of intravascular needle entrance between 14-23% of the time.[57]

Epidural steroid injections (ESIs) are a popular treatment for neck pain.[52] Complications from ESIs generally occur because of needle placement or drug administration. Common risks associated with needle placement include subdural injection, intrathecal injection and intravascular injection. Subdural injection occurs in ~ 1% of procedures, intrathecal injection occurs in ~ 0.6-10.9% of procedures, and intravascular injection, the most significant risk, occurs in ~ 2% of procedures.[53] Other risks include cervical epidural abscess, dural puncture, spinal cord trauma, infection, hematoma, nerve damage, vascular injury and cerebral vascular or pulmonary embolus.[58,59] Complications that may arise from drug administration include osteoporosis, Cushing's syndrome, avascular necrosis of bone, and steroid myopathy. While complications due to needle placement or administration of steroids are rare, they have been reported in the literature.[58,59]

Conclusion

Osteopathic manipulative treatment of the cervical spine, including but not limited to HVLA treatment, is effective for low back and neck pain and is safe. Because of the rarity of serious adverse events, trainees and practicing physicians should be provided with sufficient information so they are advised of the potential risks and able to communicate the potential risks to their patients. Prior to recommending cervical spine manipulations, physicians should conduct a thorough patient exam and medical history review to try to identify any preexisting conditions that may indicate the patient is at risk for a serious adverse event. Knowledge of absolute and relative contraindications is important to avoid complications associated with cervical manipulation. Testing for vertebral artery insufficiency in higher risk patients could be considered as well. Additionally, it is recognized that there is a need for research to distinguish the risk of VBA and CAD associated with manipulation done by specific provider types as well as research to determine the nature of the relationship between the different types of manipulative treatment and VBA and CAD.

It is the position of the American Osteopathic Association that all modalities of osteopathic manipulative treatment of the cervical spine, including HVLA, should continue to be taught at all levels of education, and that osteopathic physicians should continue to offer this form of treatment to their patients. Physicians should use a combination of medical history reviews and physical exams, diagnostic studies, and best judgment to determine if a patient has any pre-existing conditions that place the patient at risk of suffering a serious adverse event.

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Source: H322-A/24

Status: 2004; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted as Amended

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Compensation Tied to Patient Satisfaction Surveys – Osteopathic Physician

Policy Statement

The American Osteopathic Association (AOA) supports participation in patient satisfaction surveys without impact on physician payment.

Source: H323-A/24

Status: 2014; Reaffirmed as Amended 2019; 2024 Adopted as Amended

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Administrative Fees

Policy Statement

The American Osteopathic Association (AOA) has determined it is ethical for an osteopathic physician to charge patients fair and reasonable administrative fees as long as the patient is informed of these fees in advance, and the charging of administrative fees does not violate contractual or state law.

Source: H324-A/24

Status: 2004; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Adopted

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Availability of Biosimilar Products

Policy Statement

The American Osteopathic Association (AOA) advocates for policies that strengthen the biosimilar market and enable patients to access potentially more affordable therapies while preserving the physician-patient relationship and protecting patient safety policies improving access to biosimilars should:

1. Foster greater competition among prescription products

2. Support reduced co-insurance or cost sharing by the patient

3. Ensure that patients are able to access either a reference biologic or (interchangeable and/or noninterchangeable) biosimilar based on the decision made between the physician and patient, and that payors cover more than one product when available

4. Ensure that physicians maintain autonomy to designate which product is dispensed, and prevent substitutions when substitution is restricted by the physician.

Source: H325-A/24

Status: 2019 Reaffirmed as Amended; 2024 Adopted as Amended

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Medicare – Prescription Assistance for Medicare Patients

Policy Statement

The American Osteopathic Association (AOA) advocates for policies that ensure the affordability of prescription drugs under Medicare Part D and opposes restrictions that limit patients from utilizing prescription discounts and vouchers.

Source: H326-A/24

Status: 2009; 2014 Reaffirmed; 2019 Reaffirmed as Amended; 2024 Adopted as Amended

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State Graduate Medical Education Funding Alternatives

Policy Statement

The American Osteopathic Association (AOA) in responding to policy proposals aimed at funding Graduate Medical Education (GME) at the state-level will follow the recommendations outlined in the White Paper.

The AOA will work with the osteopathic community to encourage and support state-level GME funding initiatives that encompass the principles outlined within the White Paper.

State Graduate Medical Education Funding Alternatives

Policy Statement

INTRODUCTION

The following white paper and the recommendations provided within are approved to assist the American Osteopathic Association (AOA) in responding to policy proposals aimed at funding graduate medical education (GME) at the state-level; the AOA will work with the osteopathic community to encourage and support state-level GME funding initiatives that encompass the principles outlined within this paper.

WHITE PAPER—STATE GRADUATE MEDICAL EDUCATION FUNDING

BACKGROUND

Physician training requires students to attend four years of medical school, usually paying those costs out-of-pocket or through loans. Following successful completion of medical school, their training continues as medical residents. Medical residents see and treat patients under the supervision of more experienced physicians. This training usually takes place in hospitals though residents often rotate to ambulatory sites such as clinics and physician offices. On average, this residency training takes four years to complete, although highly specialized fields may require longer training.

By and large, overall funding for graduate medical education (GME) comes from patient care revenues.1 However, the federal government is currently the largest single funder of GME, providing approximately $16.2 billion in funding through the Centers for Medicare and Medicaid Services (CMS) in 2020.2 Additional funds are provided by the Department of Defense, the Department of Veterans Affairs and the health resources and services administration[43] In providing Medicare funding, congress has acknowledged that training physicians is a public good. despite that acknowledgement, and passage of federal legislation in 2020 to support 1,000 additional GME slots, federal spending continues to fall short of the amount needed to

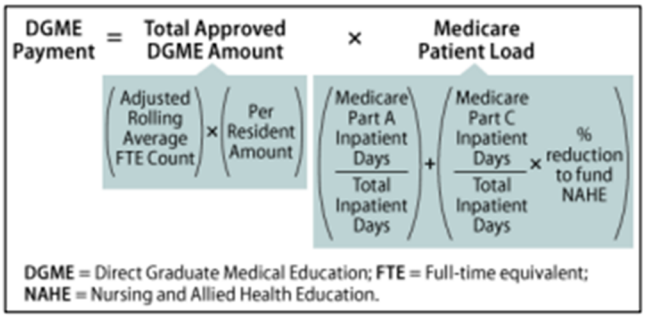
adequately address a nationwide physician shortage that is projected to reach up to 139,000 by 2033.4 this paper considers alternative funding mechanisms that states can implement to help fill the projected gap in the physician workforce.

There are two mechanisms through which Medicare and Medicaid distribute GME funding: Direct Medical Education (DME) and Indirect Medical Education (IME) payments. DME payments are based on resident salaries, supervision and other educational costs. IME payments are based on additional operating costs of a hospital with a GME program. One of the greatest obstacles to federal GME funding is the Balanced Budget Act of 1997 which limited the number of allopathic and osteopathic residents a hospital can count for purposes of DME and IME payment.5 The law also reduced the IME multiplier over a four-year period, however, the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 delayed the IME reduction. Additionally, the Budget Control Act of 2011 enacted a series of automatic budget cuts that included a 2% cut for IME payments which took effect on April 1, 2013.76

MEDICARE

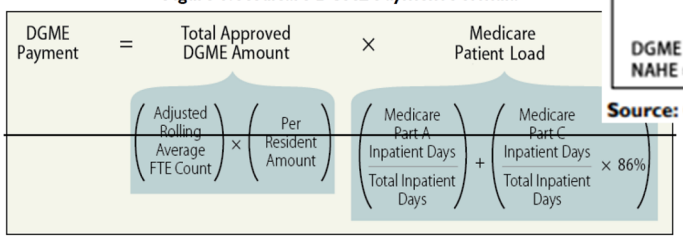
The formula for determining Medicare payments to hospitals for direct costs of approved GME programs is established in section 1886(h) of the Social Security Act.97 A DME payment is determined by multiplying a hospital-specific, base-period per resident amount by the weighted number of full-time equivalent residents working in all areas of the hospital

and the hospital's Medicare share of total inpatient days.[10][8] The Affordable Care Act amended section 1886(h)(4)(E) to allow a hospital to count residents training in non-hospital settings if the residents are engaged in patient care activities and if the hospital incurs the costs of the stipends and fringe benefits of the resident during the time residents spend in that setting.[11][9]



Source: CRS analysis of 42 U.S.C. §1395ww(h)(3) and 42 C.F.R. §413.75-88.

Figure 1. Medicare DGME Payment Formula



Source: CRS analysis of Title XVIII of the Social Security Act (SSA) and relevant regulations.
Note: The adjusted rolling average FTE count is subject to the GME cap.

As previously mentioned, IME payments are based on additional operating costs of a GME program. The factors for IME payment generally include sicker/more complex patients, maintaining stand-by capacity for certain specialized services (e.g., burn units), residents ordering more tests and trainees being less efficient in providing care. IME payments provide for the legitimate increase in costs training hospitals incur[10] IME payments are calculated by adding the individual intern/resident-to-bed ratio into a formula already established in the Medicare

statute. The current IME adjustment is calculated using a multiplier set at 1.35, which means that a teaching hospital will receive an increase of approximately 5.5% in Medicare payments for every 10-resident increase per 100 beds.[11]

MEDICAID

After medicare**,** Medicaid is the second largest funder of GME programs. A majority of states have implemented mechanisms within their Medicaid programs to supplement federal funding of GME. In most cases, Medicaid GME funding is structured similarly to Medicare, providing direct and indirect payments. The most recent data available estimates that Medicaid paid Approximately $7.39-billion to GME programs in 2022, up from $3.87 in 2012.[12]

In 2022 44 states provided an additional $7.39 billion through Medicaid to support GME.[13] of those states, twenty-four acknowledged and funded both DME and IME costs, eleven only acknowledged and funded DME costs and ten did not differentiate between DME and IME costs in some or all of their Medicaid GME payments.[14]

Medicaid Fee-for-Service

Forty**-**one states and the District of Columbia make DME and/or IME payments under the Medicaid fee-for-service program.[15] A fee-for-service program is a payment model where services are unbundled and paid for separately.[16] Sixteen states and DC fund DME and/or IME programs using a calculation method similar to Medicare's GME funding formula, sometimes in addition to other methods which usually include variations of a per-resident or lump-sum amount. The per-resident or lump-sum amounts are based on the "hospital's share of total Medicaid revenues, costs or patient volumes." Ten states reported calculating payments by a different method.[17]

Medicaid Managed Care

Capitated managed care is a state's use of risk-based capitation payments within their Medicaid program. This typically includes contracting with one or multiple managed care organizations (MCOs) to administer the Medicaid program for a defined population of Medicaid patients.[18] Thirty-nine states and DC use capitated Medicaid managed care programs.

Sixteen states and DC directly pay teaching hospitals or other teaching programs under Medicaid for DME and/or IME payments.[19] This represents an increase in the number of states who have made direct payments under managed care since 2012.[20] States who make direct Medicaid payments indicate that they wish to help train future physicians who will service Medicaid beneficiaries and that using Medicaid funds to fund GME programs will help advance state health policy goals.

Twelve states recognize and include Medicaid DME and/or IME payments in their capitated payment rates to managed care organizations, and three states use both forms of distribution.[21]

Aligning GME funding with health policy priorities

Some States continue to look to align GME funding with other health policy goals. This can include increased funding for training in certain specialties, addressing workforce shortages in rural and underserved areas and increasing faculty positions to train new physicians.[22]

Florida and Kansas

Florida and Kansas are two examples of states that link Medicaid GME payments to stated policy goals in an effort to promote accountability in the use of GME funds

This applies to both their fee-for-service (FFS) and managed care Medicaid programs, and focuses on encouraging training in primary care specialties and increasing access to care in rural and medically underserved areas.[23]

Kansas also uses GME payments to fund teaching hospitals as well as teaching sites in non-hospital settings, and promote an increased supply of physicians serving the Medicaid population. In Florida, GME payments have been extended to individual teaching physicians under FFS. The State also uses alternative sources to fund residency programs in addition to Medicaid and Medicare, including the statewide Medicaid residency program and the graduate medical education startup bonus program.[24] The former was created in 2013 with $80 million in recurring state and matching federal funds to support payments to hospitals with accredited residency programs, while the latter was created in 2015 with $100 million allocated to educating and training physicians in specialties which are in a statewide deficit. In 2022, the Florida legislature appropriated $291.64 million to these programs. [25]

Texas

In 2014, the Texas legislature allocated $12 million to several initiatives which together created 100 new residency positions across nine new primary care and two non-primary care programs.[26] In 2015, the legislature consolidated these initiatives into a single GME expansion program, to which it appropriated $49.5 million biennially. This funding has enabled the establishment of 472 additional first-year residency positions between 2014 and 2021.[27] Funding for the GME expansion program was further extended during the 2022-2023 fiscal year, with a biennial allocation of $199.1 MILLION.[28, 29]

Since 2009, the Texas Health and Human Services Commission (HHSC) has also provided supplemental funding to five state-owned teaching hospitals for approved medical residency training programs. The HHSC reimburses each hospital directly using a calculation that is based upon the hospital's self-reported Medicaid inpatient days and resident full-time equivalents. HHSC also separately provides IME payments to teaching hospitals to offset their higher patient care costs relative to non-teaching hospitals, including costs related to supervising and maintaining resident records.[30]

ADDITIONAL GME FUNDING MODELS

There are several other GME funding models that have the potential to provide revenue for GME programs. These models differ based on who would receive payment, how funds would be allocated among recipients, what mechanisms would be needed to assure accountability and whether payment would be linked to the achievement of specific performance measures. These models are not mutually exclusive and could be combined to enhance stability and

accommodate GME policy objectives. In some cases, a combination of several models would be necessary to pay for different kinds of costs to address specific educational or workforce objectives.

All-Payor System

Several states have experimented with variations on an all-payor system, which combines funding from all public and private sources to pay for state GME programs, but only Maryland's is currently operational.

Maryland implemented their all-payor system in 1977. [31] Before 2014, the state used a prospective, diagnosis-based payment model, which kept the rate of increased spending per admission below the national rate, although it was less successful at containing overall hospital spending due to increased admission rates. [32] Since 2014, Maryland has used a payment model that requires each hospital to monitor both the number and cost of admissions. Payment rates are established by the quasi-governmental Health Services Cost Review Commission, and all payors must pay a given hospital the same rate for the same service, but each hospital negotiates its own rates. [33] Maryland has built costs associated with GME funding, as well as surcharges to support an "uncompensated care pool" and a public plan for residents with chronic health conditions, into its rate-setting system. [34] Maryland also has a Medicare waiver that allows it to set Medicare payment rates. Historically, Maryland had to keep its Medicare costs below national growth for hospital payments per admission in order to maintain its waiver, but the test under the current waiver focuses on the per capita growth in hospital spending. [35]

IN ADDITION, New York previously operated an all-payor system that levied a "covered lives assessment" tax on private health insurers based upon member fees by region and type of insurance. [36] The monies collected went into two pools, one that subsidized care for individuals who were unable to pay and another that funded GME. In the late 2000s, however, the GME funding pool was reallocated toward uncompensated care in teaching hospitals, and other "high priority" items. [37]

Health Care Provider Model

Medicare pays for GME through a health care provider model. This approach links payments for clinical training to patient care activities. Because the indirect payment adjustment is intended to reflect the impact of teaching activity on a hospital's patient care costs, this model is particularly appropriate for IME payment.

Several variants of this model have been proposed to encourage more training in nonhospital settings. These variants include a direct pay approach whereby payment would follow the resident training in a nonhospital site; pro rata payment of hospitals and nonhospital sites based on agreements among the entities or a fixed allocation developed in accordance with national cost data; or payment to the entity that bears substantially of the costs of the nonhospital rotations. The first two variants would create substantial administrative burdens. Although less burdensome and disruptive, the third option appears less likely to achieve its stated goal. A voucher or "set-aside" system also could be established whereby a specified share of payment for direct training costs would be earmarked for nonhospital settings.

The principle advantage of the provider model is that regulatory, cost reporting, auditing and compliance mechanisms already are in place and well established. To this extent, these mechanisms have created persistent problems, which is also a disadvantage. This model also fails to provide financial support for training that occurs outside of patient care settings (e.g., much of the training in preventative medicine).

Education Model

Under this approach, payment would be made to a program sponsor, which would be held accountable for the way funds are allocated and expended. Sponsors could be universities, medical schools, colleges of osteopathic medicine, hospitals, consortia or any other entity whose primary purpose is providing education and/or health care services (e.g., a health department, public health agency, organized health care delivery system or hospital system.) Because this model treats direct GME costs as costs of education not patient care, adherents suggest that greater weight will be placed on educational needs as training decisions are made. In return for payment, the program sponsor (or its designees) would assume all (or substantially all) of the direct costs of operating the GME program. Allocation of GME costs and payments would be established through written agreements between the sponsor and clinical training sites. Because IME is a hospital cost, this model would not provide an adequate basis for IME payment.

The principle advantage of this approach is its focus on education. Unfortunately, it also would require a major shift in program accountability and funding, particularly when

training occurs in community teaching hospitals rather than academic medical centers, where medical schools and hospitals are linked through common ownership or other longstanding corporate or strategic ties. This approach could also discourage hospitals from maintaining or starting GME programs.

As a variant to this model, vouchers could be given directly to residents so that they could purchase their own GME. Unlike the vouchers mentioned in conjunction with the provider model, these vouchers would permit residents to control funding for their graduate training, allowing monies to flow to all training sites. In theory, this approach would enhance competition among GME programs. It is not clear, however, how much effect it would have because programs already compete for residents and rotation sites.

Besides the disadvantages mentioned above, this approach would require a new regulatory mechanism for determining which residents qualify for funding and how many positions would be funded. It also fails to address national physician workforce needs or to assure that adequate resources are available in needed specialties and geographic areas. Implementing this approach could result in substantial year-to-year fluctuations in program size, undermining the stability of existing programs and making faculty and resource allocations difficult. Residents could also be hard pressed to hold their programs accountable once training decisions are made.

Planning Model

Under this approach, funding would be channeled through planning or coordinating bodies such as GME consortia, state GME, physician workforce commissions or task forces. The primary function of these bodies would be to assess the health care needs of their communities and to allocate funds based on local workforce considerations.

Because this approach ties training and funding decisions to local health care needs, it could provide the states, payers and consumers a stronger role in allocating funds to meet workforce objectives. According to the Council on Graduate Medical Education, however, existing evidence tends to suggest that reliance on consortia to assume such a role may be premature. Adopting this model would also require development of a new regulatory mechanism to assure accountability. Payment to state entities or consortia provides little incentive to nonteaching hospitals to initiate new GME programs.

Performance Model

This model links payment to the achievement of specific performance measures or objectives. Funding could also be used to support specific projects or demonstrations on infrastructure development or particular workforce goals.

While this approach encourages innovation and quality enhancement, it is more suitable as a supplemental funding mechanism than as a primary source of GME payment. This model is also dependent on well-defined quality measures and workforce priorities. Neither may be sufficiently well developed to support all GME funding decisions at this time. This approach could also result in substantial year-to-year fluctuation in payments if all funding decisions are based on meeting specific performance measures.

CONCLUSION

With federal and state policymakers looking to cut spending, GME programs are particularly vulnerable. ”44 As states address shortfalls in federal GME funding, the AOA encourages all viable models to be examined. While all-payor systems have proven effective in some states, each state is different and may require its own unique GME funding system. Additionally, as states and the federal government implement health insurance exchanges, we encourage the exploration of using a portion of any health plan surcharge to fund GME. This will help address concerns related to workforce shortages as the covered population grows.

AOA POLICY STATEMENTS

1. The AOA supports states creation of alternative GME funding mechanisms and the alignment of this funding with their states health care priorities. Most important, within these priorities are training those specialties with the largest workforce shortages and providing care to those residents in the greatest needs (those in rural and underserved areas).

2. The AOA believes that state GME funding must account for osteopathic programs that incorporate the holistic approach to medicine, including the promotion of osteopathic principles and tenets.

3. The AOA believes that state GME funding should focus on programs that address comprehensive health care systems that deliver care through a variety of settings. This includes training residents in hospitals, rural clinics, community-based centers and patient-centered medical homes. These programs should also provide training in advancing technologies within the delivery of care.

4. The AOA believes that state GME funding should emphasize the importance of both basic and clinical research in an effort to advance the practice of medicine and the care patients receive.

5. The AOA supports the physician-led, team-based model of care. The AOA believes that state GME funding should promote this model of care by promoting interprofessional education, so that physicians can not only learn to lead the health care team, but also better understand the skills and abilities each member brings to that team.

6. Finally, this policy is intended to complement AOA Policy, Graduate Medical Education Funding and Incentives -Source: H218-A/21, and the AOA should continue to support the osteopathic community in its efforts to increase GME funding

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Source: H327-A/24

Status: 2019; 2024 Adopted as Amended

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Office Based Surgery

Policy Statement

The American Osteopathic Association (AOA) in will follow the recommendations outlined in the White Paper.

Due to its convenience and potential for cost savings, office-based surgery is an attractive option for patients; however, regulatory standards and oversight varies by state, leading to concerns over patient safety. The White Paper provides guidance.

Background

The number of surgical procedures that were once only performed in hospitals or ambulatory surgery Centers (ASCs) that are now being performed in a physician's office has grown to 53% as of 2023[1]. although there are no official safety statistics maintained for procedures conducted in office settings, various studies, such as a 2020 report published in the journal of vascular surgery, indicate a consistently strong track record of patient proponents of office-based surgery believe that many procedures can be performed safely and effectively in a physician's office due to advances in technology, anesthesia, and laparoscopic techniques. In addition, many Indicate that office-based surgery is easier to schedule and more comfortable for patients than surgery performed in a hospital. Perhaps most significant, however, is the reported cost savings for office-based surgery compared to surgery performed in a hospital. One study reported that the average cost of an Unicompartmental Knee Arthroplasty done in an office setting was an average of $20,500 less than the average charge of $46,845 for the same procedure in the hospital.[2]

Despite these benefits, the practice of office-based surgery has been controversial due to the lack of standardized rules and regulations across states. At the beginning of the 21st century, the fact that most states did not regulate office-based surgery led some observers to compare it to the "Wild West."[3] As of 2023,45 states had enacted rules, regulations or guidelines that specifically apply to office-based surgery.[4] These regulations help to ensure that office-based surgery is conducted with appropriate equipment, adequately trained personnel and established patient safety standards. However, because this practice remains unregulated or under-regulated in some states, the concern that surgery performed in a physician's office may not be as safe as surgery performed in a hospital or licensed ASC persists.

While the media has reported a number of stories of tragic outcomes following office-based surgery, the actual rate of morbidity and mortality following these procedures is hard to determine because adverse event reporting is not required in states.[5]

According to a 2017 Florida report (the most recent year for which information was available) that compared risk-adjusted hospitalization rates following surgical procedures across physician offices, freestanding ASCS, and hospital outpatient departments in Florida, rates were generally higher for office-based procedures, especially more complex procedures. [6]

Although office-based surgery may be appropriate for many surgical patients, proper attention must be given to patient safety in order to minimize adverse events.

Need for Office-Based Surgery Rule Development

States have taken different approaches to the regulation of office-based surgery. A number of state medical boards have adopted guidelines or rules for physicians to follow when performing office-based procedures. A position statement issued by the North Carolina medical board on this issue contains recommendations on physician credentialing, emergencies, performance improvement, medical records, equipment and supplies, and personnel. Any failure to comply puts a physician at risk of disciplinary action by the board.[7]

In many states, office-based surgery centers are exempt from licensure requirements that apply to hospitals and ASCS because the procedures that they perform are considered to be relatively low-risk. Some states require centers to register with a state agency such as the department of health, while others do not require any general oversight, and surgical practitioners are regulated by state medical licensing boards in the normal course of their physician oversight duties.[8]

Classification of Office-Based Surgery

Office-based surgical procedures are usually classified based on the level of anesthesia used. Typically the procedures are classified into three groups: Level 1, 2, and 3 or Class A, B, and C.[9] While not uniform, these classifications are often referred to by state medical boards and state legislators; therefore, understanding the different levels is an important basis for a discussion of office-based surgery. First, Level 1 surgical procedures are minor procedures performed under topical, local, or infiltration block anesthesia without preoperative sedation. Second, Level 2 surgical procedures are minor or major procedures performed in conjunction with oral, parenteral or intravenous sedation or under analgesic or dissociative drugs. Finally, Level 3 surgical procedures utilize general anesthesia or major conduction block anesthesia and require the support of bodily functions.[10]

Physicians and Staff in the Office-Based Surgical Facility

Unlike procedures that take place in a hospital, where credentialing requirements mean that physicians who perform surgeries are board certified or otherwise trained to do so, without state action, no such requirements exist in the office-based setting**.** While no single medical discipline has a monopoly on proper qualifications for performing office-based surgery, incidents of adverse outcomes related to a lack of specialized training may spur state licensing boards to consider instituting licensure by specialty or board certification as opposed to an unlimited scope of practice.

Equipment Required

Equipment used in office-based surgery must be kept in excellent working condition and replaced as necessary. The type of monitoring equipment required in office-based settings depends on the type of anesthesia used and individual patient needs. However, every facility must have emergency supplies immediately available, including emergency drugs and

equipment appropriate for cardiopulmonary resuscitation. This includes a defibrillator, difficult airway equipment, and drugs and equipment necessary for the treatment of malignant hyperthermia.

Transfer Agreement

Emergencies occasionally arise during surgery requiring patients to receive a level of care higher than that available in the office-based setting. Provisions must be in place to provide this care in a comprehensively outfitted and staffed facility located nearby should it be needed.

Adverse Incident Reporting

Adverse events that may occur in office-based surgical facilities include patient deaths, cardio-respiratory events, anaphylaxis or adverse drug reactions, infections, and bleeding episodes. Reporting of adverse incidents to an appropriate state entity is an important patient safety measure.

Regulation of Office-Based Surgery

Unlike hospitals and ambulatory surgery centers, not all office-based surgical facilities are subject to regulations on emergencies, fire, sanitation, drugs, staff, training, and unanticipated patient transfers. Common sense dictates that states should take steps to ensure that patients who undergo surgery in physicians' offices receive the same standard of care as patients in ambulatory surgery centers or hospitals.

~~Conclusion~~ AOA POLICY STATEMENTS

The practice of office-based surgery will likely **ONLY** continue to grow in the coming years. The following statements represent the AOA's position on the appropriate use of office-based surgery:

1. The AOA firmly believes that steps must be taken to ensure that office-based surgery is as safe for patients as hospital- or ambulatory care center-based surgery;

2. The AOA supports state licensing boards in surveying their licensees or researching the issue of office-based surgery regulation to determine if office-based surgery rule development is necessary;

3. The AOA believes that Level 1 and Level 2 procedures are acceptable to be performed in an office-based setting. However, Level 3 procedures should only be performed in an office setting that has been accredited by an accreditation organization such as the Joint Commission, the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), the Accreditation Association for Ambulatory Health Care (AAAHC) or the AAAHC'S healthcare facilities accreditation program;

4. The AOA believes that surgery performed in a physician's office must be done by a physician or non-physician clinician qualified by education and training to perform that specific procedure with appropriate physician oversight;

5. The AOA believes that only health care providers who have completed the appropriate education and training should perform office surgical procedures;

6. The AOA believes that a physician must administer the anesthesia or if a non-physician clinician administers the anesthesia, a supervising physician must be physically present in the office-based surgical facility during the administration of anesthesia and remain physically available until the patient has fully recovered and has been discharged from anesthesia care. In case of an emergency, personnel with training in advanced resuscitative techniques should be immediately available until the patient is discharged;

7. The AOA believes office-based surgical facilities must have the appropriate medications, equipment, and monitors necessary to perform the surgery and administer the anesthesia in a safe manner. The equipment and monitors must be maintained, tested, and inspected according to the manufacturer's specifications;

8. The AOA believes physicians and non-physician clinicians who perform office-based surgery shall be responsible for coordinating and ensuring appropriate care for patients who require emergent, unexpected postoperative transfer and/or hospitalization. Written protocols must be in place for timely transfer to an accredited hospital located within reasonable proximity to the office. Office personnel must be appropriately trained in emergency protocols in order to be able to respond when emergency or extended services are needed to protect the health or well-being of the patients;

9. The AOA supports reporting of adverse incidents related to surgical procedures performed in an office setting to a state entity, as required and appropriate, provided that these disclosures will be considered confidential and protected from discovery or disclosure; and

10. The AOA supports the position that state medical licensing boards are the appropriate entity to create and implement regulations regarding office-based surgery. 2019

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Source: H328-A/24

Status: 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2019 Reaffirmed; 2024 Adopted as Amended

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Uniform Pathway of Licensing of Osteopathic Physicians

Policy Statement

The American Osteopathic Association (AOA) states that the examination of the National Board of Osteopathic Medical Examiners (NBOME) must remain as the avenue for the licensure of osteopathic physicians and supports a uniform pathway of licensing osteopathic physicians through the mechanisms of the NBOME to be effective after 12/31/19.

Source: H329-A/24

Status: 1991; 1993 Reaffirmed as Amended ; 1998 Reaffirmed; 2003 Reaffirmed; 2008 Reaffirmed; 2013 Reaffirmed as Amended; 2019 Reaffirmed as Amended; 2024 Adopted

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Safe Haven Non-Reporting Protection for Physicians-Support for

Policy Statement

The American Osteopathic Association (AOA) states that the examination of the National Board of Osteopathic Medical Examiners (NBOME) must remain as the avenue for the licensure of osteopathic physicians and supports a uniform pathway of licensing osteopathic physicians through the mechanisms of the NBOME to be effective after 12/31/19.

White paper

Introduction

In the wake of rising burnout rates among U.S. medical professionals—a phenomenon that has dire consequences for both healthcare providers and the patients they serve—there is compelling evidence that a significant proportion of U.S. physicians and medical students experience symptoms of burnout, compounded by the stigma surrounding mental health and substance use treatment. Consequently, there is a critical demand for policy revisions that offer support without the fear of disciplinary actions or professional repercussions by advocating for 'safe haven non-reporting' protections, we aim to foster an environment where physicians can seek necessary treatment confidentially, thereby safeguarding their well-being and ensuring the continued provision of high-quality care to their patients. Through detailed recommendations, this paper intends to pave the way for a more supportive, understanding, and resilient healthcare system.

Background

Burnout among US medical students, residents and practicing physicians is a significant problem that negatively impacts medical professionals as well as the patients that they serve. In 2021, a research study found that 62.8% of U.S. physicians

Exhibited at least one symptom of burnout, up from 38.2% in 2020, 43.9% in 2017, 54.4% in 2014, and 45.5% in 2011**.** In addition, 54% of medical students, interns and residents reported experiencing symptoms of burnout.[2]

Burnout is characterized by a “wide array of signs, symptoms and related conditions, including fatigue, loss of empathy, detachment, depression and suicidal ideation.”[3] It has also been shown to negatively impact a physician’s prescribing habits, test ordering, risk of malpractice suits, and whether patients adhere to their recommendations.[4] Although the aforementioned description does not explicitly reference substance use disorders, we will hereafter reference symptoms of burnout, mental health and substance use issues (and their treatment) interchangeably.

Even when resources are available to help physicians and students address symptoms of burnout; however, both groups report similar concerns about pursuing them. For purposes of this policy paper, we will focus on concerns regarding lack of confidentiality and possible

disciplinary or discriminatory action by schools, employers, state medical licensing boards and other academic or professional entities.

Federation of state medical boards' recommendations

In 2016, the Federation of State Medical Boards (FSMB) convened a Workgroup on Physician Wellness and Burnout (Workgroup) to study the issue of physician burnout and drafted recommendations to help groups in the medical community better address this issue. The Workgroup found that although numerous resources exist to help medical students and physicians experiencing symptoms of burnout or impairment through academic institutions, medical licensing boards and state physician health programs, social and professional pressures make students and physicians reluctant to seek treatment or to report seeking it.[5] Both medical students and physicians cited fears that seeking help would result in documentation on academic or professional records which could lead to discrimination or denial of a medical license, and ultimately jeopardize their ability to practice medicine.

Although the FSMB recommendations came out in 2018, a 2023 Medscape report found that some issues remain, with four in 10 physicians stating that they avoided seeking help for depression or burnout due to concerns about their employers or state medical boards finding out.[6]

Further, despite evidence showing that a past history of mental health or substance use disorders does not reliably predict future risk to the public, approximately one-quarter of state licensing applications still contain questions about applicants' histories with these issues. As of October 2023, 26 state medical boards had removed intrusive language from their licensure applications, and 11 states were in the process of making these changes.[7] this shift signifies a growing recognition within the medical community of the importance of addressing mental health concerns without stigma or fear of professional repercussions; however, additional action is needed to enact these changes in all 50 states.

Although medical licensing boards previously asked about both mental and physical health, historical practices showed a disparity in the specificity and intensity of questions, with mental health inquiries being more probing. Recent changes across various states now reflect a more balanced approach, ensuring questions are limited to conditions that directly impact a physician's ability to practice medicine.

The response of medical licensing boards to physicians' disclosures of mental health issues has also evolved, aiming for a more supportive approach. forty-seven states now offer physician health programs, which typically serve as an alternative to discipline if a physician voluntarily discloses a mental or behavioral health condition and remains in compliance with a recommended treatment plan.[8] these changes highlight a commitment to reducing the stigma around mental health and supporting physicians in seeking care, thereby promoting a healthier, safer environment for physicians and their patients.

In addition to the deterrent effect that questions from medical licensing boards regarding mental health appear to have on physicians' willingness to seek help when needed or report seeking it, courts have found that many such questions run afoul of the Americans with Disabilities Act (ADA). The ADA protects individuals with disabilities, including psychiatric disabilities, from discrimination. Professional licensing bodies are not exempt from the requirements of the ADA, and courts have stated that "[public entities] may not administer a licensing or certification

program in a manner that subjects qualified individuals with disability to discrimination on the basis of disability."[8] Public entities such as a medical licensing board also may not "impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability … unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered."[9]

In order to encourage medical students and physicians to seek appropriate treatment for mental health and substance use disorders, and ensure that medical licensing boards comply with the ADA, the FSMB encourages medical licensing boards to adopt policies that support physician "safe haven non-reporting."

"Safe haven non-reporting" allows physicians who are receiving appropriate treatment for mental health or substance use issues who are monitored and in good standing with their confidential treatment program to (re)apply for licensure without having to disclose their treatment to the board. Only disclosures related to issues that are not being appropriately treated and could inhibit a physician's ability to safely practice medicine would be required.

AOA POLICY STATEMENTS

The AOA adopts the following statements as its official position on "safe haven non-reporting:"

1. The presence or history of a mental health or substance use disorder does not automatically render a physician unfit to practice medicine, and the AOA opposes discrimination or disciplinary action against a physician or medical student based solely on the presence of such a disorder, without taking into consideration the individual's behavior or treatment.

2. The AOA urges state medical licensing boards and credentialing entities to regard physical and mental health disorders similarly and refrain from asking about past history of mental health or substance use diagnoses or treatment on licensure applications or renewals which conflicts with the Americans with disabilities act**.** Instead, the AOA encourages entities to focus on whether any *current* physical or mental disorders are present which may impair that individual's ability to safely practice medicine. The AOA further encourages physician licensing and credentialing entities to offer a "safe haven non-reporting" option for physician applicants who are undergoing appropriate treatment for current mental health or substance use disorders. This alternative helps to ensure confidentiality of such treatment for the individual physician while ensuring patient safety.

3. If physician licensing and credentialing entities decide to use questions related to mental health or substance use disorders on an application or renewal, the AOA encourages entities to consider phrasing them similarly to questions about physical health. For example:

   "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)"

4. "Appropriate treatment" includes physician participation provided through state physician health programs recognized by the Federation of State Physician Health Programs, or programs following similar standards and guidelines, and adherence to treatment recommendations.

5. Finally, the AOA encourages medical educational and professional entities, as well organizations throughout the medical community, to support and educate students and physicians about confidential treatment and "safe haven non-reporting" options, in order to encourage these individuals to seek appropriate treatment without fear of documentation, disciplinary action or other repercussions.

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Source: H330-A/24

Status: 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2019 Reaffirmed; 2024 Adopted as Amended

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Any Willing Provider Legislation and the Right to Privately Contract – Support For

Policy Statement

The American Osteopathic Association (AOA) encourages and supports the passage of legislation that will ensure the freedom of patients and physicians to enter into private contracts for health care services without regard to restrictions by any third-party payer.

The AOA supports changes in statutes and regulations to allow physicians individually and as defined groups to negotiate fair contracts with private sector and public sector health plans.

The AOA supports legislation that will allow any qualified physician (DO/MD) to negotiate with any third-party payer the terms for service to be provided.

The AOA supports legislation that will require any third-party carrier to provide prompt and complete explanation to any requesting physician (DO/MD) whom it may deem unqualified.

Source: H333-A/24

Status: 2004; 2009 Reaffirmed; 2014; 2019 Reaffirmed; 2024 Adopted as Amended

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Pharmacy Benefit Managers-Increased Regulation of

Policy Statement

The American Osteopathic Association (AOA) will follow the recommendations outlined in the White Paper.

WHITE PAPER– PHARMACY BENEFIT MANAGERS-INCREASED REGULATION OF

Policy Statement

INTRODUCTION

The affordability of prescription drugs remains a major issue for patients and, by extension, their physicians, and pharmacy benefit managers (PBMS) continue to play a role in driving up the cost of drugs in the United States. Therefore, a comprehensive white paper on pharmacy benefit managers (PBMS) remains necessary, to enable us to support legislation to address the various ways in which PBMS extract profits from the drug supply chain and keep medication costs high for patients.

Background

The high cost of drugs is a major concern in the U.S., where consumers pay two to four times more for prescription drugs than the rest of the world.[1] Increased drug prices have resulted in patient noncompliance, with sometimes fatal consequences, as patients are either unable to afford their prescription medications or are forced to choose between buying them or other necessities like food and shelter.

One major factor impacting a country's drug spending is the fact that many other governments around the world directly regulate or negotiate drug prices**.** By contrast, with the exception of drugs identified under the inflation reduction act**,** the U.S. government does not directly negotiate drug prices, instead leaving it up to individual insurers to negotiate prices with drug makers. This fragmented and opaque system often results in different prices for different buyers, a power imbalance that favors corporate entities at the expense of consumers.

While numerous factors contribute to prescription drug pricing and affordability in the U.S., for purposes of this policy paper we will focus on the role of pharmacy benefit managers (PBMs).[2]

Pharmacy Benefit Managers

PBMs are companies hired by insurers, employers, and government entities to manage prescription drug programs on behalf of health plan beneficiaries.[3] Originating several decades ago as processors of prescription drug claims for insurers, for which they earned a flat fee, PBMs initially lowered drug prices by forming large networks of health plan customers which enabled them to negotiate discounts with drug makers. Since then, consolidation among PBMs

has concentrated an 80% market share in the hands of three major players (CVS Caremark, Express Scripts and OptumRX), and drug prices have risen as a result.[4]

PBMs affect numerous aspects of the drug supply chain, and they are adept at leveraging their power with drug makers, employers and pharmacies to extract profits that they keep for themselves rather than passing them on to patients. As a result, patients pay cost shares that do not reflect the actual lower cost of the drug, which increases out-of-pocket costs and co-pays.

The following represents a summary of PBM revenue sources:

Rebates. PBMs decide which drugs will be covered on a prescription drug plan or plan formulary, and drug makers often pay “rebates” or other fees to PBMs to have their drugs included. Drug makers then pass these costs on to consumers in the form of higher drug prices.

PBMs also determine which pharmacies will be included in a prescription drug plan's network and how much they will be paid. Sometimes, PBMs entice plan sponsors to require beneficiaries to use a mail order pharmacy – usually one with financial ties to the PBM – for certain medications.

Prior Authorization. PBMs use prior-authorization requirements to steer patients to formulary drugs regardless of their efficacy, by requiring them to obtain prior authorization if they or their providers prefer to continue the original (non-formulary) drug. This can result

in harm to patients who may miss doses or experience other negative effects from adjusting to a new drug, which may not be as effective as the one they were previously stable on.

Spread pricing. “Spread pricing” refers to the difference between what a PBM charges an insurer for a drug and what it reimburses the pharmacy for it. Neither the insurer nor the pharmacy knows what the PBM charges or reimburses the other for a particular drug, and PBMs take advantage of this lack of transparency to pocket the spread.

Gag clauses (partially mooted by the federal Patient Right to Know Drug Prices and the Know the Lowest Price Acts of 2018). Prior to the passage of the aforementioned Acts in October 2018, PBMs in most states could utilize “gag clauses” to prevent pharmacists from telling customers when their copayment amount would exceed the out-of-pocket cost of a drug. PBMs then kept the customer’s overpayment, known as a “clawback,” as profit. The Acts banned gag clauses, giving pharmacists the option – but *not* requiring them – to tell patients when a drug would cost less out-of-pocket.

Direct and Indirect Remuneration (DIR) Fees. DIR refers to the monies that a PBM may collect from a dispensing pharmacy to offset member costs.[5] The Centers for Medicare and Medicaid Services (CMS) originally created DIR as a way to track rebates and other price adjustments applied to Medicare Part D prescription drug plans that were not captured at the point of sale and that resulted in savings to a PBM, and ultimately to CMS (in theory).

Since its inception, DIR has transformed into a catchall term for any fees a pharmacy pays to a PBM, including fees associated with quality-based bonus payment models PBMS impose on pharmacies**,** such as fees to participate in the PBM’s network or fees paid for failing to meet

certain quality measures.[6] PBMs have also begun expanding the use of DIR from just Medicare Part D plans to commercial plans, and pocketing the savings. While some DIR fees are legitimate, many are assessed in an arbitrary and opaque manner that prevents pharmacies from fully understanding how much they will be reimbursed for a prescription when entering into a PBM contract. In addition, DIR fees are now charged at the point of sale, potentially causing cash flow problems for small and community-based pharmacies that are trying to budget for, and ultimately implement, new patient services.

State Action

As of 2023, all 50 states have taken some legislative action related to PBMS, in an effort to bring more fairness and transparency to their impact on drug pricing**.**

In a majority of states**,** PBMs are now required to be licensed by a state agency.[7] The agency promulgates rules for licensure, which may include state approval of compensation arrangements between PBMs and pharmacies to ensure that reimbursement rates are fair and reasonable, or requirements that PBMs disclose aggregate rebates to purchasers.

Some states, including Arkansas, Florida, Indiana, New Jersey, New Mexico and Wyoming, have enacted bills that focus on ensuring that the rebates that PBMS negotiate from drug manufacturers are passed on to consumers. these laws require that patients' cost-sharing responsibility be calculated at the point of sale and reduced by a percentage of those rebates, aiming to lower out-of-pocket expenses.[8]

Eighteen states currently have laws preventing PBMs from requiring or incentivizing patients to use pharmacies that they own or are affiliated with, which are often mail-order pharmacies.[9] PBM "steerage" towards mail-order pharmacies could drive some independent pharmacies out of business, thereby costing patients access to other services that their local pharmacies may provide[10] All major PBMs have their own mail-order pharmacies, which allow them to tightly control formularies and steer patients towards drugs for which they receive financial benefits, as well as to reap rewards from spread pricing. Large PBMs can also exclude other independent mail-order pharmacies from their networks and negotiate prices that allow them to undercut competitors, which raises antitrust questions.

PBMs were originally created to save consumers money, and increased regulation by states could theoretically drive up operating costs and reduce savings for consumers; however, extensive consolidation among PBMs has since tilted the balance of power away from consumers and obscured prices as well as the ability of outsiders to determine PBMs' real effect on the costs of the drug supply chain. States have little power to prevent future PBM mergers, thus increased regulation and transparency requirements may be their only effective tools.

AOA POLICY STATEMENTS

The AOA adopts the following statements as its official position on PBMs:

1. State and federal governments should work to ensure that PBMs function as originally intended; that is, to save patients money. In order to accomplish this goal, a multi-

pronged approach that incorporates various elements below in order to target PBMs' various revenue sources and address misaligned incentives should be considered.

2. PBMs should be required to publicly disclose any rebates or other "financial benefits" that they receive from other members of the drug supply chain and pass through a certain percentage to the plan sponsor. They should also be prevented from utilizing prior authorization requirements to steer patients to formulary drugs or mail-order pharmacies to which they have financial ties.

3. In order to improve the viability of independent pharmacies and preserve competition, PBMs should be prohibited from charging pharmacies retroactive DIR fees.

4. Capping patient copayments at the pharmacy reimbursement rate or the cost without insurance would help address PBM clawbacks.

5. The AOA supports health policy which promotes making life saving medications (i.e. epinephrine for anaphylaxis, naloxone for drug overdose, and insulin/glucagon for diabetes) free for uninsured patients and a fully covered benefit for insured patients.

6. The U.S. Department of Justice should enforce antitrust protections to prevent additional PBM market consolidation, which is likely to lead to further drug formulary restrictions and reductions in the number of – and PBM reimbursement for – independent pharmacies.

7. Lastly, governmental action to improve PBM transparency is key. The Federal Trade Commission (FTC) has the unique power to shed light on the effect of PBMs on the drug supply chain through its Section 6(b) authority and accompanying subpoena power. Section 6(b) allows the FTC to "conduct wide-ranging economic studies that do not have a specific law enforcement purpose," and it could exercise this authority to obtain PBM rebate and fee information and to analyze PBMs' effects on drug pricing.[1]

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10. **STAFF IN THE OFFICE OF TECHNOLOGY AND THE DIVISION OF PRIVACY AND IDENTITY PROTECTION. A BRIEF OVERVIEW OF THE FEDERAL TRADE COMMISSION'S INVESTIGATIVE, LAW ENFORCEMENT, AND RULEMAKING AUTHORITY. FEDERAL TRADE COMMISSION. AUGUST 10, 2022.** https://www.ftc.gov/about-ftc/mission/enforcement-authority.

11. ***IBID***

Source: H334-A/24

Status: 2019; 2024 Adopted as Amended

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Diversity In Leadership Positions

Policy Statement

The American Osteopathic Association (AOA) supports increased awareness of and encourages diversity in its leadership positions and encourages its divisional and special societies to do the same.

Source: H336-A/24

Status: 1999, 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Adopted

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Due Process for Alleged Impaired Physicians

Policy Statement

The American Osteopathic Association (AOA) believes that, except in the case of summary suspension necessary to protect patients from imminent harm, no adverse action be taken against the staff privileges of a physician by a hospital, managed care organization or insurer based on a claim of physician impairment without a suitable due process hearing in accordance with medical staff bylaws to determine the facts related to the allegations of impairment, and, where appropriate, a careful clinical evaluation of the physician.

Source: H337-A/24

Status: 1999; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted

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National Practitioner Data Bank-Membership Action

Policy Statement

The American Osteopathic Association (AOA) believes that adverse membership actions which do not involve professional competence or conduct such as nonpayment of dues, CME deficiencies and other association matters shall not be reported to the National Practitioner Data Bank (NPDB) unless otherwise required by law; and that final actions of expulsion of members from the American Osteopathic Association shall, when all appeal mechanisms have been exhausted by the osteopathic physicians, be reported to the National Practitioner Data Bank.

Source: H338-A/24

Status: 1999; 2004 Reaffirmed; 2009; 2014; 2019 Reaffirmed; 2024 Adopted

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Promoting Diversity in AOA Membership and Leadership

Policy Statement

The American Osteopathic Association (AOA) reaffirms its commitment to promote diversity within the osteopathic profession.

The AOA endorses programs to encourage increased diversity in enrollment at colleges of osteopathic medicine.

The AOA will work to identify and encourage such qualified individuals for participation in those osteopathic affiliate and national activities which foster leadership opportunities.

Source: H339-A/24

Status: 1979 Reaffirmed; 1983 Reaffirmed as Amended; 1988 Reaffirmed; 1994 Reaffirmed; 1999 Reaffirmed; 2004 Reaffirmed as Amended; 2009 Reaffirmed as Amended; 2014 Reaffirmed as Amended; 2019 Reaffirmed as Amended; 2024 Adopted as Amended

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Clarification on the Terms "Osteopathy, and "Osteopath" in the United States

Policy Statement

The American Osteopathic Association's (AOA) policy regarding the preferential terms to be used in reference to the osteopathic medical profession has been updated over the years.

The AOA supports restricting the use of all osteopathic terminology in the United States to students and graduates of osteopathic medical schools accredited by the commission on osteopathic college accreditation, or those physicians having completed an ACGME accredited residency with osteopathic recognition or osteopathic neuromusculoskeletal medicine we will continue to advocate for term protection in state and federal laws and rules in the interest of transparency and patient safety.

Terms which should be protected include "osteopathic medicine," "osteopathic physician," "osteopathic manipulative treatment," and "osteopathic manipulative medicine," and related abbreviations. Additionally, “osteopath”, “osteopathy”, and other terms derived from the word, "osteopathy," which implies qualification for the complete practice of medicine in the us, should also be protected. Deliberate alternative usage of these terms by non-physicians may be confusing to the public and may constitute unprofessional conduct or fraud.

Source: H340-A/24

Status: 2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed; 2024 Adopted as Amended

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Increased awareness of Mental Health Conditions in Nursing Home Residents

Policy Statement

The American Osteopathic Association (AOA) recognize the prevalence of mental health conditions among nursing home residents and that the AOA physicians who practice in skilled nursing facilities and other long term care facilities to use evidence-based medicine to address mental health conditions among residents in these facilities.

Source: H341-A/24

Status: 2019; 2024 Adopted as Amended

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Airline Medical Kits

Policy Statement

The American Osteopathic Association (AOA) supports the current Federal Aviation Administration (FAA) Final Rules on Airline Emergency Equipment.

The AOA recommends that the federal aviation administration (FAA) review and update rules on airline in-flight medical kits (IFMK) emergency equipment and medications to better address inflight medical emergencies such as anaphylaxis, nausea, and opioid overdose.

The AOA recommends a mandatory five-year review of IFMK contents to respond to advances and emerging aeromedical technologies and practices.

Source: H342-A/24

Status: 1998, 2003 Reaffirmed as Amended; 2008 Reaffirmed as Amended; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Referred to AOCOPM; 2024 Adopted as Amended

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Whistleblower Policy

Policy Statement

The American Osteopathic Association (AOA) requires trustees, officers, employees, and volunteers to observe high standards of business and personal ethics in the conduct of their duties and responsibilities. As employees and representatives of the AOA, they must practice honesty and integrity in fulfilling their responsibilities and comply with all applicable laws and regulations as noted in the Whistleblower Policy.

Whistleblower Policy

The American Osteopathic Association (AOA) requires trustees, officers, employees, and volunteers to observe high standards of business and personal ethics in the conduct of their duties and responsibilities. As employees and representatives of the AOA, they must practice honesty and integrity in fulfilling their responsibilities and comply with all applicable laws and regulations.

Applicability
This policy applies to all AOA employees, members of the board of trustees, and members of AOA bureaus, committees, councils, and task forces.

Reporting Responsibility
This whistleblower policy is intended to encourage and enable employees and others with knowledge of misconduct to raise concerns internally so that the AOA can address and correct inappropriate conduct and actions. It is the responsibility of all persons as outlined above to report concerns about suspected violations of law or regulations that govern the AOA's operations.

No Retaliation
It is the policy of the AOA that there shall not be any personal or professional retaliation against any person who in good faith reports a suspected violation of law or other significant misconduct. Any employee who retaliates against a whistleblower shall be subject to disciplinary action up to and including termination of employment. Any member who retaliates against a whistleblower shall be subject to disciplinary action (censure, probation, suspension, expulsion) as outlined in the AOA bylaws (article vii, section 1, part h).

Reporting Procedure
Employees: the AOA encourages open communications. Employees are encouraged to share their questions and concerns, with their supervisor as an initial step. supervisors and managers are required to report complaints or concerns about suspected legal violations in writing to any of the following: the AOA's general counsel, chief financial officer, chief executive officer, the human resources department leader or the AOA president, who have the responsibility to investigate or have investigated all reported complaints.

Individuals uncomfortable with reporting a concern to their supervisor or who are not satisfied with the response provided by their supervisor are encouraged to report the concern directly to any of the individuals listed above.

members: members are encouraged to report their concerns to the chair or secretary of their bureau, committee, council, or task force or to a member of the board of trustees or the chief executive officer. bureau, council, committee or task force chairs and secretaries or trustees receiving such reports or complaints are required to report them in writing to any of the following: the AOA's compliance officer (general counsel), chief financial officer, chief executive officer, human resources department leader or the AOA president. AOA's compliance officer (general counsel) will have the responsibility to investigate or to have investigated all whistleblower reports or complaints.

The AOA complies with all applicable requirements of federal and state statutes and regulations concerning "whistleblower" activity, including, without limitation, the Illinois whistleblower act [1] among its provisions, the Illinois whistleblower act prohibits an employer from discharging or otherwise retaliating against an employee for any of the following actions:

- disclosing to a law enforcement agency or other government agency information that the employee reasonably believes discloses a violation of any state or federal law, rule, or regulation.

- refusing to participate in an activity that would result in a violation of any state or federal law, rule, or regulation.

The Illinois whistleblower act also prohibits an employer from making, adopting or enforcing any rule, regulation or policy that prevents its employees from disclosing information to a government or law enforcement agency when the employees have reasonable cause to believe that the information concerns a violation of a state or federal law, rule or regulation.

Compliance Officer

The AOA's compliance officer is the general counsel. The compliance officer is responsible for ensuring that all complaints about unethical or illegal conduct are investigated and resolved. the compliance officer will advise the chief executive officer and board of trustees of all complaints and their resolution and will report at least annually to the finance committee and the audit committee on compliance activity relating to accounting or alleged financial improprieties.

Accounting And Auditing Matters

The AOA'S compliance officer shall immediately notify the chief executive officer and the audit committee and/or finance committee of any concerns or complaint regarding corporate accounting practices, internal controls or auditing and work with the committee until the matter is resolved.

Acting In Good Faith

[1] 740 ILCS 174/5, et seq.

To qualify for protection as a whistleblower, anyone filing a written complaint concerning a violation or suspected violation must be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation. reporting of allegations that prove (a) not to be substantiated, and (b) have been made maliciously or knowingly to be false will be viewed as a serious offense for which appropriate disciplinary action can be taken. persons who make allegations with malice or knew that the allegations were false when made do not enjoy any of the protections afforded under state or federal law.

Confidentiality

Reports of violations or suspected violations may be submitted on a confidential basis by the complainant. reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation.

Handling Of Reported Violations

Any employee receiving an allegation of violation of ethics or law shall report the allegation to the AOA compliance officer. The compliance officer will notify the person who submitted a complaint and acknowledge receipt of the report of violation or suspected violation. All reports will be promptly investigated and appropriate corrective action will be taken if warranted by the investigation.

Source: H343-A/24

Status: 2019; 2024 Adopted as Amended

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Opioid Crisis, Causes

Policy Statement

The American Osteopathic Association (AOA) shall advocate to Congress and appropriate governmental and regulatory agencies to identify the contributing causes of the opioid crisis and to develop solutions which target those causes.

The AOA educate members of these entities around the comprehensive causes of the problems, and advocate for policies and positions that seek to identify and mitigate the opioid crisis recognizing that physicians and other health care resources are critical to address the management of opioid use disorder.

Source: H345-A/24

Status: 2019; 2024 Adopted as Amended

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Expanding Opioid Reversal Agents availability and accessibility- Promoting Emergency use in Communities to treat Opioid Overdose

Policy Statement

The American Osteopathic Association (AOA) advocate for the implementation of steady funding for community programs to increase the accessibility of opioid reversal agents coming to market through federal, state, and local channels; and that the AOA advocate for implementation of such programs in all states.

The AOA encourages states to incorporate physician expertise in developing and administering such programs.

Source: H347-A/24

Status: 2019; 2024 Adopted as Amended

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GME Equity Annual Report

Policy Statement

The 2024 House of Delegates accepts the AOA Board of Trustees GME Equity 2024 Annual Report as outlined.

That the AOA supports non-legislative, properly vetted legislative and regulatory and other public policy solutions that assure GME equity for osteopathic medical students and also assure universal acceptance of applications from qualified osteopathic medical students and universal acceptance of COMLEX when a test score is required by a GME program; and, that the AOA Board of Trustees report back semi-annually to the members beginning with the midyear meeting on the progress that has been made to assure equity exists for osteopathic graduates to enter residency programs in all fields of medicine and surgery

Source: H348-A/24

Status: 2023; 2024 Adopted

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SPECIAL MEETING OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
PUBLIC AFFAIRS - RESOLUTION ROSTER
As of September 28, 2020

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:

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

Res. No.	Resolution Title	Submitted By	Reference Committee
H400	Interference in the Physician-Patient Relationship by Personal Injury Attorneys and Insurance Carrier Agents (H400-15)	BSAPH / BSA	Public
H401	Osteopathic Name and Identity (H401-A/15)	BOE	Public
H402	Public Education Regarding the Importance and Safety of Vaccines for Infants, Children, and Adults (H402-A/15)	BSAPH	Public
H403	Support for the Advisory Committee on Immunization Practices (ACIP) Recommendations (H403-A/15)	BSAPH	Public
H404	Vaccination Rates – Daycare Notification to Parents (H404-A/15)	BSGA	Public
H405	Protection of Safe Water Supply (H405-A/15)	BFHP / BSAPH	Public
H406	Antibiotic Stewardship (H407-A/15)	BSAPH	Public
H407	Vaccines for Children Program (H408-A/15)	BSAPH	Public
H408	Seat Belt Laws – Primary Enforcement (H409-A/15)	BSGA	Public
H409	Intrauterine Fetal Demise Awareness (H410-A/15)	BSAPH	Public
H410	Antifreeze Poisoning (H411-A/15)	BSAPH	Public
H411	Aircraft Emergency Medical Supplies (H412-A/15)	BFHP	Public
H412	Animals in Medical Research (H413-A/15)	BSAPH	Public
H413	Cancer (H415-A/15)	BSAPH	Public
H414	Cardiopulmonary Resuscitation, Training (H416-A/15)	BSAPH	Public
H415	Children's Safety Seats (H418-A/15)	BSAPH	Public
H416	Death – Right to Die (H419-A/15)	BSGA	Public
H417	Environmental Responsibility--Waste Materials (H420-A/15)	BSAPH	Public
H418	Firearms and Non-Powdered Guns - Education for Users (H421-A/15)	BFHP	Public
H419	Genetic Manipulation of Food Products – Consumers Right to Know (H422-A/15)	BSAPH	Public
H420	Condom Usage – Health Education (H423-A/15)	BSAPH	Public

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PUBLIC AFFAIRS - RESOLUTION ROSTER
As of September 28, 2020

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

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PUBLIC AFFAIRS - RESOLUTION ROSTER
As of September 28, 2020

Res. No.	Resolution Title	Submitted By	Reference Committee
H446	Background Checks and Firearms Safety Training as a Condition of Firearms Purchase	BFHP	Public
H447	Fentanyl Testing Strips	AOAAM	Public
H448	Firearms Policy	BFHP	Public
H449	Homeless Support	OPSC	Public
H450	Medical Amnesty for Underage Consumption of Alcohol	AOAAM	Public
H451	Opposition to Abstinence-Only Sex Education	SOMA	Public
H452	REFERRED RESOLUTION: Breastfeeding While on Medication Assisted Treatment (MAT)	BSAPH	Public
H453	REFERRED SUNSET RESOLUTION: H-411 - A/2019: H413-A/14 Epidemic Terrorist Attack Victims, Government Responsibility of Health Care	BFHP	Public
H454	REFERRED SUNSET RESOLUTION: H429 A/14 Minorities, Underrepresented (URM) – Increasing Numbers of Applicants…	BSAPH	Public
H455	REFERRED RESOLUTION: Regulation of E-Cigarettes and Nicotine Vaping	BSAPH	Public
H456	Recognizing Health Care as a Human Right	MOA	Public
H457	Support a Culture of Patient Safety and Speaking Up from Medical Students and Preceptors in Healthcare Settings	SOMA	Public
H458	WITHDRAWN	IOMA	Public

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
PUBLIC AFFAIRS (400 SERIES)

House of Delegates' Reference Committee Description:
Committee on Public Affairs (400 series)
This reference committee reviews and considers matters relating to public and industrial health, research, and physical fitness.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-400	Endorse Nutritionally Balanced, Low Cost or Free Meals for Children in Schools	ACOFP	Public Affairs	ADOPTED as AMENDED
H-401	Supporting Public Policy to Encourage Wholesome Food Donations to Those in Need in America	MOA	Public Affairs	ADOPTED
H-402	Collection of Public Health Data Concerning Firearm Fatalities	MOA	Public Affairs	ADOPTED as AMENDED
H-403	Patient Centered Treatment for Pain Management and Appropriate use of Opioids	MOA	Public Affairs	ADOPTED
H-404	Physician Communication to Patients Regarding ~~COVID-19 Prevention~~ PUBLIC HEALTH CRISES	NYSOMS	Public Affairs	ADOPTED as AMENDED
H-405	Addressing Dermatologic Health Disparities in People of Color	SOMA	Public Affairs	NOT ADOPTED
H-406	Addressing Law Enforcement Disproportionate use of Force During Interactions with Marginalized Groups as a Public Health Issue	SOMA	Public Affairs	NOT ADOPTED
H-407	Addressing The Change in Climate Effects on National Health	SOMA	Public Affairs	ADOPTED as AMENDED
H-408	Increased Law Enforcement Resources and Training for Response in Mental Health Crises	SOMA	Public Affairs	REFERRED
H-409	Referred Resolution H437-A/19 – AOA Firearm Policy	BFHP	Public Affairs	ADOPTED
H-410	Improving Outcomes in Behavioral Health Care in the Emergency Department	BFHP	Public Affairs	ADOPTED as AMENDED
H-411	COVID-19 Anti-Asian Discrimination and Abuse	MOA	Public Affairs	NOT ADOPTED
H-412	Drug Samples (SR-Source: H327-A/16)	BFHP	Public Affairs	ADOPTED

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
PUBLIC AFFAIRS (400 SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-413	Concussion, Return-to-Play and Return-to-Learn (SR-Source: H352-A/16)	CSHA	Public Affairs	ADOPTED
H-414	Osteopathic Medicine -- Autonomy of (SR-Source: H401-A/16)	BOT	Public Affairs	ADOPTED
H-415	Chelation Therapy (SR-Source: H406-A/16)	BORPH	Public Affairs	ADOPTED
H-416	Minority Health and Osteopathic Medical Education (SR-Source: H409-A/16)	BORPH	Public Affairs	ADOPTED as AMENDED
H-417	Obesity in Children (SR-Source: H410-A/16)	BORPH	Public Affairs	ADOPTED
H-418	~~Fitness~~, Sports, FITNESS and Nutrition (SR-Source: H412-A/16)	BORPH	Public Affairs	ADOPTED
H-419	Plastic Beverage and Food Container Recycling Act (SR-Source: H413-A/16)	BORPH	Public Affairs	ADOPTED
H-420	Childhood And Teenage Sexual Exposure (SR-Source: H414-A/16)	BORPH	Public Affairs	ADOPTED as AMENDED
H-421	Tobacco Control – The Framework Convention on (SR-Source: H415-A/16)	BIOM	Public Affairs	ADOPTED
H-422	Damage to Hearing from use of Headphones (SR-Source: H417-A/16)	BORPH	Public Affairs	ADOPTED
H-423	Dangers of the "Choking Game" (SR-Source: H418-A/16)	BORPH	Public Affairs	ADOPTED
H-424	Medical USE OF Cannabis – Research On (SR-Source: H419-A/16)	BORPH	Public Affairs	ADOPTED
H-425	Sports And Prevention of Traumatic Brain Injury (SR-Source: H420-A/16)	CSHA	Public Affairs	ADOPTED *for sunset*

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
PUBLIC AFFAIRS (400 SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-426	Blood Donors, Protection from Depletion of Iron (SR-Source: H423-A/16)	BORPH	Public Affairs	ADOPTED
H-427	5-2-1-0**+10** Campaign for America's Children (SR-Source: H424-A/16)	BORPH	Public Affairs	ADOPTED as AMENDED
H-428	Healthy, Hunger-Free Kids Act (SR-Source: H425-A/16)	BORPH	Public Affairs	ADOPTED *for sunset*
H-429	Obesity Epidemic – Addressing the American (SR-Source: H427-A/16)	BORPH	Public Affairs	ADOPTED
H-430	Mandatory Influenza Vaccine of Healthcare Personnel (SR-Source: H429-A/16)	BORPH	Public Affairs	ADOPTED
H-431	Title X Funded Family Planning Services – Support for (SR-Source: H433-A/16)	BORPH	Public Affairs	ADOPTED
H-432	Shackling Of Pregnant Inmates (SR-Source: H435-A/16)	BORPH	Public Affairs	ADOPTED
H-433	Cancer Clinical Trials – Explore Incentives to Increase Patient Involvement In (SR-Source: H438-A/16)	BORPH	Public Affairs	REFERRED
H-434	Lesbian, Gay, Bisexual, Transgender, Queer / Questioning **INTERSEX, ASEXUAL** Protection Laws (SR-Source: H439-A/16)	BFHP/CSHA	Public Affairs	ADOPTED as AMENDED
H-435	Substance Use Disorders (SUD) – Evidence Based Treatment Programs for (SR-Source: H440-A/16)	BORPH	Public Affairs	REFERRED
H-436	Osteopathic Manipulative Medicine (OMM) and Osteopathic Manipulative Treatment (OMT) – Affirming the Scientific and Medical Foundation of (SR-Source: H605-A/16)	BORPH	Public Affairs	ADOPTED
H-437	Third Party Payors Changing Classes of Medications (SR-Source: H607-A/16)	CERA	Public Affairs	ADOPTED
H-438	Physician Comparative Utilization & Profiling (SR-Source: H610-A/16)	CERA	Public Affairs	ADOPTED as AMENDED

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
PUBLIC AFFAIRS (400 SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-439	Physician Supply in Rural, Underserved United States – Recommendations for Improving (SR-Source: H613-A/16)	BFHP/CSHA	Public Affairs	ADOPTED
H-440	Alternative Payment Models – Ensuring DO Opportunities and Patient Access in (SR-Source: H616-A/16)	CSHA/CERA	Public Affairs	ADOPTED
H-441	Health Insurance Coverage for Medical and Surgical Treatments for Good Oral Health (SR-Source: H619-A/16)	CERA	Public Affairs	ADOPTED
H-442	Physician Profiles (SR-Source: H623-A/16)	CSHA	Public Affairs	ADOPTED

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102nd ANNUAL AOA HOUSE OF DELEGATES
JULY 17, 2022, MEETING
RESOLUTION ROSTER (400 SERIES)

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTIONS:
Committee on Public Affairs (400 series)
This reference committee reviews and considers matters relating to public and industrial health, research and physical fitness.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-400	Drugs-Prescription Discounts (SR - Source: H400-A/17)	BFHP	Public Affairs	Adopted
H-401	AOA Support of Public Health Service (SR- Source: H406-A/17)	BFHP	Public Affairs	Adopted
H-402	Counseling Female Patients on Reproductive Issues (SR - Source: H407-A/17)	CSHA	Public Affairs	Adopted as Amended
H-403	Genetic Testing (SR- Source: H412-A/17)	BFHP	Public Affairs	Adopted
H-404	Substance Impaired and Distracted Driving (SR- Source: H413-A/17)	CSHA	Public Affairs	Adopted
H-405	Accessibility to Breast Cancer Prevention, Detection, Diagnosis and Treatment (SR – Source: H408-A/17)	BORPH	Public Affairs	Adopted
H-406	Support For Prenatal and Pediatric Hospice and Palliative Care (SR - Source: H409-A/17)	BORPH	Public Affairs	Adopted
H-407	AOA Support for Hospice Care Programs (SR - Source: H411-A/17)	BORPH	Public Affairs	Adopted as Amended
H-408	Treatment of Obesity (SR- Source: H414-A/17)	BORPH	Public Affairs	Adopted as Amended
H-409	Women's Contraceptive Coverage Legislation (SR- Source: H416-A/17)	BORPH	Public Affairs	Adopted as Amended
H-410	Promotion for the Requirement of All Sporting Events to Have Access to an Automated External Defibrillator (AED) To Treat Commotio Cordis (SR - Source: H418-A/17)	BORPH	Public Affairs	Adopted as Amended
H-411	Meningococcal Vaccine Recommendations (SR- Source: H419-A/17)	BORPH	Public Affairs	Adopted
H-412	PSA-Based Screening for Prostate Cancer (SR- Source: H422-A/17)	BORPH	Public Affairs	Adopted
H-413	Mandates on School Lunches (SR - Source: H423-A/17)	BORPH	Public Affairs	Adopted
H-414	Judicious Use of Antimicrobial (SR- Source: H425-A/17)	BORPH	Public Affairs	Adopted as Amended

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H-415	Anti-Bullying Law (SR- Source: H426-A/17)	BORPH	Public Affairs	Adopted as Amended
H-416	Promotion, Protection and Support of Breastfeeding (SR - Source: H428-A/17)	BORPH	Public Affairs	Adopted as Amended
H-417	Protocol and Guidelines for Emergency Medical Identification (SR- Source: H429-A/17)	BORPH	Public Affairs	Adopted as Amended
H-418	Organ Donation – Opposition to Financial Incentives for Organ Donors (SR - Source: H430-A/17)	BORPH	Public Affairs	Adopted as Amended
H-419	Violence in the Entertainment Media (SR - Source: H432-A/17)	BORPH	Public Affairs	Adopted
H-420	Stem Cell Research (SR - Source: H433-A/17)	BORPH	Public Affairs	Adopted
H-421	Education on Human Papillomavirus Vaccination (SR- Source: H434-A/17)	BORPH	Public Affairs	Adopted
H-422	Daily Physical Education for Grades K-12 (SR- Source: H435-A/17)	BORPH	Public Affairs	Adopted
H-423	Use of Tobacco Products (SR- Source: H436-A/17)	BORPH	Public Affairs	Adopted as Amended
H-424	Policy Statement on End of Life Care (SR- Source: H438-A/17)	BORPH	Public Affairs	Referred
H-425	Powdered Caffeine (SR - Source: H439-A/17)	BORPH	Public Affairs	Adopted
H-426	Health Insurance Coverage for Residential Treatment and Inpatient Treatment of Eating Disorders (SR- Source: H440-A/17)	BORPH	Public Affairs	Adopted
H-427	Violence and Abuse Prevention and Education (SR- Source: H441-A/17)	BORPH	Public Affairs	Adopted
H-428	Recreational Marijuana Use by Physicians, Students and Patients – White Paper (SR- Source: H442-A/17)	BORPH	Public Affairs	Adopted as Amended
H-429	Harm Reduction Modalities for People Who Inject Drugs – White Paper (SR- Source: H443-A/17)	BORPH	Public Affairs	Adopted as Amended
H-430	Medication For Indigent Patients (SR- Source: H444-A/17)	BORPH	Public Affairs	Adopted
H-431	AOA Policies on Opioids and Substance Use – White Paper	BORPH	Public Affairs	Adopted as Amended
H-432	Addressing Diversity, Equity and Inclusion as a Profession	POMA	Public Affairs	Referred
H-433	Support Interpretation of Medical Information among the General Public	OOA	Public Affairs	Referred

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RESOLUTION ROSTER (400 SERIES)

H-434	Recognizing the Disproportionate Prevalence of Cardiovascular Disease in the African American Population as a Public Health Issue	SOMA	Public Affairs	Adopted as Amended
H-435	Standardized Screening for Intimate Partner Violence for all Individuals	SOMA	Public Affairs	Referred
H-436	Support for Increased Crisis Intervention Team Training for Law Enforcement	SOMA	Public Affairs	Adopted as Amended
H-437	Increased Research on the Public Health Impacts of Decriminalizing Possession of all Illicit Drugs	SOMA	Public Affairs	Adopted

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103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (400 SERIES) -w/ACTION
As of 07-24-23

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTIONS:
Committee on Public Affairs (400 series)
This reference committee reviews and considers matters relating to public and industrial health, research and physical fitness.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-400	Breastfeeding Mothers – Protecting (SR-Source:H426-A/18)	BFHP	Public Affairs	Adopted
H-401	**PROTECTING PATIENTS FROM SEXUAL ABUSE IN THE HEALTHCARE SETTING** ~~American Osteopathic Association Makes Public Statement and Develops Protocols To Prevent Sexual Abuse of Patients~~ (SR-Source:H427-A/18)	BORPH	Public Affairs	Adopted as Amended
H-402	Breastfeeding Exclusivity (SR-Source:H425-A/18)	BORPH	Public Affairs	Adopted as Amended
H-403	Cervical Cancer, Screening for (SR-Source:H405-A/18)	BORPH	Public Affairs	Adopted as Amended
H-404	Choosing Wisely Campaign (SR-Source:H404-A/18)	BORPH	Public Affairs	Adopted as Amended
H-405	Concerns in Homeless Population (SR-Source:H428-A/18)	BORPH	Public Affairs	Adopted as Amended
H-406	Disaster Preparedness Planning (SR-Source:H417-A/18)	BORPH	Public Affairs	Adopted as Amended
H-407	Energy Drinks (SR-Source:H422-A/18)	BORPH	Public Affairs	Adopted
H-408	Environmental Health (SR-Source:H402-A/18)	BORPH	Public Affairs	Adopted
H-409	Fire Prevention – Teaching of (SR-Source:H408-A/18)	BORPH	Public Affairs	Adopted
H-410	Gambling Disorder (SR-Source:H401-A/18)	BORPH	Public Affairs	Adopted
H-411	Healthy Lifestyles (SR-Source:H406-A/18)	BORPH	Public Affairs	Adopted as Amended

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Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-412	Healthy People **2030** ~~2020~~ (SR-Source:H409-A/18)	BORPH	Public Affairs	Adopted as Amended
H-413	Human Immunodeficiency Virus (HIV) Testing – Clinical and Public Health Application of (SR-Source:H424-A/18)	BORPH	Public Affairs	Referred to BORPH
H-414	Immunizations (SR-Source:H411-A/18)	BORPH	Public Affairs	Adopted
H-415	Medication Take-Back Program (SR-Source:H407-A/18)	BORPH	Public Affairs	Adopted
H-416	"Opioid Overdose" Deaths in America – Epidemic (SR-Source:H423-A/18)	BORPH	Public Affairs	Adopted as Amended
H-417	Osteopathic Manipulative Treatment of Somatic Dysfunction of the Head, Safety in (SR-Source:H420-A/18)	BORPH	Public Affairs	Adopted as Amended
H-418	Patient Education (SR-Source:H412-A/18)	BORPH	Public Affairs	Adopted as Amended
H-419	Policy Statement on End-of-Life Care - Referred Sunset Res. No. H424-A/2022 (SR-Source:H438-A/17)	BORPH	Public Affairs	Adopted as Amended
H-420	Pediatric Medical Imaging (SR-Source:H416-A/18)	BORPH	Public Affairs	Adopted
H-421	Pediatric Obesity (SR-Source:H419-A/18)	BORPH	Public Affairs	Adopted as Amended
H-422	Tuberculosis Medical Training (SR-Source:H415-A/18)	BORPH	Public Affairs	Adopted
H-423	Distracted Driving (SR-Source:H418-A/18)	CSHA	Public Affairs	Adopted
H-424	Artificial Intelligence in Health Care – Task Force	MAOPS	Public Affairs	Adopted as Amended
H-425	Recognizing the Issue of Weight Bias in Healthcare	OPSC	Public Affairs	Adopted as Amended
H-426	Osteopathic Medicine is High-Value Care	OPSC/MOMA	Public Affairs	Adopted
H-427	Voter Registration as a Social Determinant of Health	SOMA	Public Affairs	Not Adopted

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Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-428	Amendment to H444-A/20 “Adopting and Promoting Non-Stigmatizing Language for Substance Use Disorders”	SOMA	Public Affairs	Adopted as Amended
H-429	Supporting Access to Over-the-Counter Oral Contraceptive Pills	SOMA	Public Affairs	Adopted as Amended

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2024 RESOLUTION ROSTER (400 SERIES) W/ACTION
As of 07-22-24

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
Committee on Public Affairs (400 series)
This reference committee reviews and considers matters relating to public and industrial health, research and physical fitness.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-400	Employee Retirement Income Security Act of 1974 (SR-Source-H414-A/19)	BFHP	Public Affairs	Adopted
H-401	Firearm Safety (SR-Source-H425-A/19)	BFHP	Public Affairs	Adopted
H-402	Protecting Patients with Private Insurance from Balance Billing (SR-Source-H426-A/19)	BFHP	Public Affairs	Referred to BFHP
H-403	Physician-Patient Relationship as Related to Proposed Gun Control Laws, Protection of the (SR-Source-H428-A/19)	BFHP	Public Affairs	Adopted
H-404	CMS Rules on Psychotropic Medications in Nursing Facilities (SR-Source-H429-A/19)	BFHP	Public Affairs	Adopted as Amended
H-405	Community Pharmacies; Required Notification of Primary Care Providers Regarding Vaccination Administration (SR-Source-H436-A/19)	BFHP	Public Affairs	Adopted
H-406	Discrimination in Healthcare (SR-Source-H406-A/19)	BFHP	Public Affairs	Adopted as Amended
H-407	Public Information – Correction of, About the Osteopathic Profession (SR-Source-H403-A/19)	BIOM	Public Affairs	Adopted as Amended
H-408	Pharmaceuticals – Support Efforts to Encourage the Proper Disposal of Unused and Expired (SR-Source-H408-A/19)	BORPH	Public Affairs	Adopted as Amended
H-409	Comparative Effectiveness Research (SR-Source-H410-A/19)	BORPH	Public Affairs	Adopted as Amended
H-410	Fluoridation (SR-Source-H412-A/19)	BORPH	Public Affairs	Adopted
H-411	Lead Exposure in Children – Prevention, Detection, and Management (SR-Source-H422-A/19)	BORPH	Public Affairs	Adopted as Amended
H-412	Hepatitis C Screening (SR-Source-H423-A/19)	BORPH	Public Affairs	Adopted as Amended
H-413	Raw Milk – Health Risks (SR-Source-H416-A/19)	BORPH	Public Affairs	Referred to BORPH

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Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-414	Vaccines (SR-Source-H417-A/19)	BORPH	Public Affairs	Adopted
H-415	Domestic and Intimate Partner Violence – Development of Programs to Prevent (SR-Source-H418-A/19)	BORPH	Public Affairs	Adopted
H-416	Alert Network – Silver and Gold (SR-Source-H404-A/19)	BORPH	Public Affairs	Adopted as Amended
H-417	Recognizing Food Insecurity as a Public Health Issue (SR-Source-H435-A/19)	BORPH	Public Affairs	Adopted
H-418	Alcohol Abuse (SR-Source-H405-A/19)	BORPH	Public Affairs	Adopted as Amended
H-419	Occupant Protection in Passenger Vehicles (SR-Source-H427-A/19)	BORPH	Public Affairs	Adopted as Amended
H-420	Sudden Infant Death Syndrome (SR-Source-H407-A/19)	BORPH	Public Affairs	Adopted as Amended
H-421	Patient Safety and use for Patients with Pain Conditions (SR-Source-H400-A/19)	BORPH	Public Affairs	Adopted as Amended
H-422	Human Trafficking – Awareness as a Global Health Problem (SR-Source-H401-A/19)	BORPH	Public Affairs	Adopted
H-423	Same-Sex Relationships and Healthy Families (SR-Source-H402-A/19)	BORPH	Public Affairs	Adopted as Amended
H-424	Maternal and Child Healthcare Block Grants (SR-Source-H413-A/19)	CERA	Public Affairs	Adopted as Amended
H-425	Health Care Fraud (SR-Source-H419-A/19)	CERA	Public Affairs	Adopted
H-426	Automated External Defibrillator Availability (SR-Source-H420-A/19)	CSHA	Public Affairs	Adopted
H-427	Enhanced Legislative Support for Behavioral and Mental Health Care	BEL	Public Affairs	Adopted
H-428	Recognition of Intellectual and Developmental Disabilities as a Health Disparity	BEL	Public Affairs	Adopted as Amended
H-429	Artificial Intelligence in Healthcare Report and Action Plan (Resolution H424-A/23 Artificial Intelligence in Healthcare)	BORPH	Public Affairs	Adopted as Amended
H-430	Human Immunodeficiency Virus (HIV) Testing – Clinical and Public Health Application of (SR-Source-H424-A/18)	BORPH	Public Affairs	Adopted as Amended
H-431	Warning the Profession and Public about the Potential Dangers of Kratom Use	MOA (Michigan)	Public Affairs	Adopted as Amended

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Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-432	Continuous Positive Airway Pressure (CPAP), Obstructive Sleep Apnea	OOA (Ohio)	Public Affairs	Referred to OOA
H-433	Against the use of High Fructose Corn Syrup	OOA (Ohio)	Public Affairs	Adopted as Amended
H-434	Recognizing Breast Implant Illness (BII) and Promoting Informed Consent for Breast Implant procedures	OOA (Ohio)	Public Affairs	Referred to BORPH
H-435	Addressing the compromised safety of Healthcare Workers practicing in areas of conflict and the resulting threat to Healthcare Infrastructure	SOMA	Public Affairs	Adopted as Amended
H-436	Childhood and Teenage Sexual Exposure (Amendment to Policy H420-A/21)	SOMA	Public Affairs	Adopted as Amended
H-437	Regulation of Cannabis Edibles	MOMA (Mississippi)	Public Affairs	Referred to MOMA

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Interference in the Physician-Patient Relationship by Personal Injury Attorneys and Insurance Carrier Agents

Policy Statement

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

Source: H400-A/20

Status: 2015; 2020 Reaffirmed

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Public Education Regarding the Importance and Safety of Vaccines for Infants, Children, and Adults

Policy Statement

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

Source: H402-A/20

Status: 2015; 2020 Reaffirmed

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Support for the Advisory Committee on Immunization Practices (ACIP) Recommendations

Policy Statement

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

Source: H403-A/20

Status: 2015; 2020 Reaffirmed

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Vaccination Rates – Daycare Notification to Parents

Policy Statement

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

Source: H404-A/20

Status: 2015; 2020 Reaffirmed

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Protection of Safe Water Supply

Policy Statement

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

Source: H405-A/20

Status: 2015; 2020 Reaffirmed

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Antibiotic Stewardship

Policy Statement

The American Osteopathic Association (AOA), supports the five core actions outlined in the National Strategy for Combating Antibiotic-Resistant Bacteria and calls upon osteopathic physicians to adopt the principles of responsible antibiotic use, or antibiotic stewardship, which is a commitment to use antibiotics only when they are medically necessary.

Source: H406-A/20

Status: 2015; 2020 Reaffirmed

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Vaccines for Children Program

Policy Statement

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

Source: H407-A/20

Status: 2005; 2010 Reaffirmed as Amended; 2015 Reaffirmed; 2020 Reaffirmed

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Seat Belt Laws – Primary Enforcement

Policy Statement

The American Osteopathic Association (AOA) supports the primary enforcement seat belt laws in every state.

Source: H408-A/20

Status: 2005; 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

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Intrauterine Fetal Demise Awareness

Policy Statement

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

Source: H409-A/20

Status: 2010; 2015 Reaffirmed as Amended; 2020 Reaffirmed

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Aircraft Emergency Medical Supplies

Policy Statement

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

Source: H411-A/20

Status: 1984; 1989 Reaffirmed as Amended; 1995 Reaffirmed; 2000 Reaffirmed, 2005 Reaffirmed as Amended; 2010 Reaffirmed; 2015 Reaffirmed as Amended; 2020 Reaffirmed

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Animals in Medical Research

Policy Statement

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

Source: H412-A/20

Status: 1990; 1995 Reaffirmed; 2000 Reaffirmed as Amended; 2005 Reaffirmed as Amended; 2010 Reaffirmed; 2015 Reaffirmed as Amended; 2020 Reaffirmed

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Cancer

Policy Statement

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

Source: H413-A/20

Status: 1974; 1980 Reaffirmed, 1985 Reaffirmed; 1990 Reaffirmed as Amended, 1995, 2000 Reaffirmed, 2005 Reaffirmed as Amended; 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

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Cardiopulmonary Resuscitation - Training

Policy Statement

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

Source: H414-A/20

Status: 1980; 1985 Reaffirmed as Amended; 1990 Reaffirmed; 1995 Reaffirmed; 2000 Reaffirmed; 2005 Reaffirmed; 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

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Children's Safety Seats

Policy Statement

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

Source: H415-A/20

Status: 1985; 1990 Reaffirmed as Amended; 1995 Reaffirmed; 2000 Reaffirmed as Amended; 2005 Reaffirmed; 2010 Reaffirmed as Amended; 2015 Reaffirmed; 2020 Reaffirmed

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Death – Right to Die

Policy Statement

The American Osteopathic Association (AOA) believes that the decision to withhold or withdraw treatment from a patient whose prognosis is terminal, or when death is imminent, shall be based upon the wishes of the patient or their family or legal representative if the patient lacks capacity to act on their own behalf as mandated by applicable law.

Source: H416-A/20

Status: 1979; 1984 Reaffirmed as Amended; 1989 Reaffirmed; 1995 Reaffirmed; 2000 Reaffirmed; 2005 Reaffirmed; 2010 Reaffirmed as Amended; 2015 Reaffirmed; 2020 Reaffirmed

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Environmental Responsibility--Waste Materials

Policy Statement

The American Osteopathic Association (AOA) supports recycling.

Source: H417-A/20

Status: 1995; 2000 Reaffirmed as Amended; 2005 Reaffirmed as Amended; 2010 Reaffirmed as Amended; 2015 Reaffirmed; 2020 Reaffirmed

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Firearms and Non-Powdered Guns - Education for Users

Policy Statement

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

Source: H418-A/20

Status: 1990; 1995 Reaffirmed; 2000 Reaffirmed; 2005 Reaffirmed; 2010 Reaffirmed as Amended; 2015 Reaffirmed as Amended; 2020 Reaffirmed as Amended

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Genetic Manipulation of Food Products – Consumers Right to Know

Policy Statement

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

Source: H419-A/20

Status: 2000, 2005 Reaffirmed as Amended, 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

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Condom Usage – Health Education

Policy Statement

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

Source: H420-A/20

Status: 1995; 2000 Reaffirmed as Amended; 2005 Reaffirmed, 2010 Reaffirmed; 2015 Reaffirmed; 2020 Reaffirmed

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Support of Literacy Programs

Policy Statement

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

Source: H421-A/20

Status: 1990; 1995 Reaffirmed as Amended; 2000 Reaffirmed, 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

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Tanning Devices

Policy Statement

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

Source: H422-A/20

Status: 1990; 1995 Revised; 2000 Reaffirmed, 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

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Tobacco Settlement Funds

Policy Statement

The American Osteopathic Association (AOA) supports the use of the tobacco settlement fund exclusively for health care services, education and research.

Source: H423-A/20

Status: 2000, 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

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Healthy Family - Support of

Policy Statement

The American Osteopathic Association (AOA) recommends that their members support healthy families by encouraging families to do the following:

(1) Try to eat at least one meal per day together, using healthful nutritional guidelines;
(2) A set time be spent together as a family to help with schoolwork and include reading to and with children;
(3) Encouraging media-free time;
(4) Limiting exposure to violence; and
(5) Engaging in a healthy lifestyle that includes exercise.

Source: H424-A/20

Status: 2005; 2010 Revised; 2015 Reaffirmed; 2020 Reaffirmed

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Immunization of 9 to 26 Year Old Male and Females with Human Papilloma Virus Vaccine

Policy Statement

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

Source: H425-A/20

Status: 2010; 2015 Reaffirmed; 2020 Reaffirmed as Amended

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Drugs, Curbing Counterfeit

Policy Statement

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

Source: H426-A/20

Status: 2005; 2010 Revised; 2015 Reaffirmed; 2020 Reaffirmed

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Sleep Disorders - Promoting the Understanding and Prevention of

Policy Statement

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

Source: H427-A/20

Status: 2005; 2010 Revised; 2015 Reaffirmed; 2020 Reaffirmed

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Minority Health Disparities

Policy Statement

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

POSITION STATEMENT ON MINORITY HEALTH DISPARITIES

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

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

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

Cultural competency is a set of academic and personal skills that allow one to understand and appreciate cultural differences among groups. The better a healthcare professional understands a patient's behavior, values and other personal factors, the more likely that patient will receive effective, high quality care.

Racial and ethnic healthcare disparities caused by problems with access to, and utilization of, quality care may be alleviated through improvements in the cultural competency skills of physicians. Healthcare disparities may also be alleviated through effective recruitment of underrepresented minorities into health professions schools.

The Centers for Disease Control, in conjunction with the U.S. Department of Health and Human Services, created an Office of Minority Health in 1985. Through this collaboration, the Racial and Ethnic Approaches to Community Health Act (REACH) was designed to identify and eliminate disparities in a number of major areas. Disparities in access to care as well as quality of care in these areas result in poorer outcomes for racial and ethnic minorities.

The identified areas of disparity include: 1) infant mortality; 2) breast and cervical cancer screening and malignancy; 3) cardiovascular and cerebrovascular disease; 4) diabetes; 5) infectious diseases (i.e., Covid-19, influenza, HIV/Aids); and 6) child and adult

immunizations. In addition, serious disparities exist in the provision of care for mental health problems, substance abuse and suicide prevention.

The American Osteopathic Association calls for the following actions to be taken to address minority health disparities and to improve cultural competency of its physician members:

1. The education of physicians regarding racial and ethnic healthcare needs, including disparities in the areas listed above;
2. The promotion of education regarding implicit or explicit biases among healthcare professionals that may play a role in clinical decision-making;
3. The evaluation and analysis of medical information which would permit the targeting of populations who are at greatest risk;
4. The identification of new methods to involve physician members in the communities in which they serve;
5. The identification and integration of available resources to better serve minority communities, including houses of worship, schools and local government;
6. The inclusion of cultural competency training throughout the continuum of osteopathic education;
7. The development of strategies to actively recruit underrepresented minority physicians into the profession in both primary care and subspecialties;
8. The development of approaches to encourage all physicians to provide care to underserved minority populations.

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

Source: H428-A/20

Status: 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed as Amended

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Infant Walker (Mobile) – Ban on the Manufacture, Sale and Use of

Policy Statement

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

Source: H429-A/20

Status: 2003; 2010 Revised; 2015 Reaffirmed; 2020 Reaffirmed

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Develop In-Vitro Fertilization Standards of Care

Policy Statement

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

Source: H430-A/20

Status: 2010; 2015 Reaffirmed; 2020 Reaffirmed as Amended

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Continued Support of Combating Bio-Terrorism Activities

Policy Statement

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

Source: H432-A/20

Status: 2010; 2015 Reaffirmed; 2020 Adopted as Amended

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Childhood Obesity – Worsening Epidemic in the American Society

Policy Statement

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

Source: H433-A/20

Status: 2010; 2015 Reaffirmed; 2020 Reaffirmed

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Texting While Driving

Policy Statement

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

Source: H435-A/20

Status: 2010; 2015 Reaffirmed; 2020 Reaffirmed

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Silver Alert System

Policy Statement

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

Source: H436-A/20

Status: 2010; 2015 Reaffirmed; 2020 Reaffirmed

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National Institutes of Health Grants

Policy Statement

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

Source: H437-A/20

Status: 2010; 2015 Reaffirmed; 2020 Reaffirmed as Amended

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Screening for Breast Cancer

Policy Statement

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

Source: H438-A/20

Status: 2010; 2015 Reaffirmed as Amended; 2020 Reaffirmed

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Gender Identity Non-Discrimination

Policy Statement

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

Source: H439-A/20

Status: 2010; 2015 Reaffirmed; 2020 Reaffirmed

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Traumatic Brain Injury Awareness

Policy Statement

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

Source: H440-A/20

Status: 2010; 2015 Reaffirmed; 2020 Reaffirmed as Amended

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Support for Family Caregivers

Policy Statement

The American Osteopathic Association (AOA), recognizing a growing number of family caregivers have unaddressed needs related to personal health and wellbeing, supports caregivers by participating in the developing public debate regarding health care policy to include family caregivers and encourages its members to gain education in caregiver illnesses, resources in their area and treat and/ refer when appropriate.

Source: H441-A/20

Status: 2010; 2015 Reaffirmed; 2020 Reaffirmed

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Firearm Violence

Policy Statement

The American Osteopathic Association (AOA):

(1) Supports the federal government's January 2013 clarification, "that no federal law in any way prohibits doctors or other health care providers from reporting their patients' threats of violence to the authorities, and issuing guidance making clear that the Affordable Care Act does not prevent doctors from talking to patients about gun safety;"

(2) Supports funding for the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and other research entities to conduct research on firearm violence and to provide recommendations on reducing firearm violence;

(3) Supports promotion of policies that will increase access to mental health services and for the appropriate coverage of mental health services by public and private health care programs; and

(4) Encourages enhanced education of gun safety and safe handling of firearms; and

(5) Approves the attached Policy Statement on Firearm Violence.

AOA Policy Statement – Firearm Violence

The American Osteopathic Association (AOA) is dedicated to preventing violence in our communities, especially the increased prevalence of firearm violence. As physicians, we see first-hand the devastating consequences of violence to victims and their families. The AOA recognizes that laws, regulations, and policies have the potential to decrease the occurrence of violence, especially firearm violence, in our communities. The AOA supports:

Preserving the Ability of Physicians to Educate and Counsel their Patients on Firearm Violence

Preserving the rights of physicians and other health care professionals to counsel patients on prevention, including the prevention of injury or death as a result of firearms is critical. Physicians play an important role in preventing firearm injuries through health screenings, patient counseling, and referral to mental health services. The AOA supports the Administration's January 2013 clarification, "that no federal law in any way prohibits doctors or other health care providers from reporting their patients' threats of violence to the authorities, and issuing guidance making clear that the Affordable Care Act does not prevent doctors from talking to patients about gun safety." We must ensure that no federal or state law hinders, restricts, or criminalizes the patient-physician relationship.

Advancing Research to Reduce Firearm Violence

Advancing research to reduce firearm violence is a public health issue that deserves the allocation of appropriate resources. The AOA supports funding for the Centers for Disease

Control (CDC) and Prevention, the National Institutes of Health (NIH), and other research entities to conduct research on firearm violence and to provide recommendations on reducing firearm violence.

Improving Access to Mental Health Services and Resources

Improving access to mental health services and resources is essential to reducing firearm violence. The AOA supports promotion of policies that will increase access to mental health services and for the appropriate coverage of mental health services by public and private health care programs. Access to mental health services and resources for young adults should be a priority. The early identification of diagnosable mental health issues and subsequent treatment is vital to reducing firearm violence.

Source: H442-A/20

Status: 2013; 2015 Revised; 2020 Reaffirmed as Amended

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Adopting and Promoting Non-Stigmatizing Language for Substance Use Disorders

Policy Statement

The American Osteopathic Association (AOA) commit to the use of clinically- accurate, non-stigmatizing, person-first language (“substance use disorder,” “recovery,” “substance misuse,” “positive or negative urine screen,” and “person with a substance use disorder”) and discourage the use of stigmatizing terminology (“substance abuse,” “substance abuser,” “addict,” “alcoholic,” and “clean/dirty”) in future publications, resolutions, and educational materials both in print and online; and, that the AOA encourages its members and organizational partners to incorporate clinically-accurate, non-stigmatizing, person first language into their clinical practice.

Source: H444-A/20

Status: 2020

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AOA Response to Novel Public Health Threats

Policy Statement

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

Source: H445-A/20

Status: 2020

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Background Checks and Firearms Safety Training as a Condition of Firearms Purchase

Policy Statement

The American Osteopathic Association (AOA) recognizes public health data demonstrating the impact of firearms on mortality and wellness in the United States and will support federal legislation requiring comprehensive background checks for all firearm purchases, including sales by gun dealers, sales at gun shows, and online sales for purchase, which does not extend to firearms transfers between family members or firearms attained through inheritance; and, that the AOA will support efforts to require firearms safety training, including military or law enforcement training, as a condition to purchase any class of firearms; and that H421-A/15 is superseded by this resolution.

Source: H446-A/20

Status: 2020

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Homeless Support

Policy Statement

The American Osteopathic Association (AOA) reaffirm support for state and federal efforts, including efforts by private organizations, as well as those enumerated in the 2018 House of Delegates resolution number H-428 – A/2018, and that those efforts include addressing social determinants affecting health, substance abuse programs, mental health resources, clinical care programs and provision of stable housing for all homeless individuals that are seeking temporary or permanent shelter.

Source: H449-A/20

Status: 2020 Reaffirmed as Amended

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

Policy Statement

The attached White paper, titled, "Breastfeeding While on Medication Assisted Treatment (MAT)", and the recommendations within be adopted as policy.

Breastfeeding While on Medication Assisted Therapy

Introduction

Opioid use among pregnant women is a growing public health concern. In 2014, the Centers for Disease Control and Prevention (CDC) recorded a 333% national increase in opioid use disorder (OUD) among pregnant women, with 6.5 cases of opioid abuse per 1,000 hospital deliveries, compared to 1.5 cases in 1999.[1] Opioid use during pregnancy is not uncommon; as many as 1 in 5 pregnant women enrolled in Medicaid filled an opioid prescription during their pregnancy.[2] Prenatal opioid exposure has been directly linked to adverse health outcomes for mothers and babies across the nation. These adverse health outcomes include increased maternal mortality and morbidity, poor fetal development, preterm births, still births, birth defects, and increased incidence of Neonatal Abstinence Syndrome (NAS).[3]

Studies have found that breastfeeding among women being treated for OUD offers many benefits that can mitigate the impacts of OUD for the mother and infant. Benefits include, but are not limited to, reduced hospital stays and decreased need for morphine treatment in infants born with NAS.[4]

Opioid Use Disorder Treatment

Medication Assisted Treatment, or MAT, is defined as the use of medications in combination with counseling and behavioral therapies to treat OUD and aid patients in sustaining their recovery.[5] MAT may be utilized with pregnant women to treat opioid use disorder and avoid the severe consequences associated with untreated opioid use disorder or stopping opioid usage too quickly. The U.S. Food and Drug Administration has approved three medications, buprenorphine, methadone, and naltrexone for OUD treatment.[5]

Naltrexone is the newest therapy approved by the U.S. Food and Drug Administration to treat opioid use disorder in pregnant women. Since it is also the least studied therapy, there is a research gap regarding the safety and effectiveness of naltrexone during pregnancy.[6] As a result, MAT for pregnant women commonly entails the use of methadone or buprenorphine with naloxone, in conjunction with coordinated care among behavioral therapists, OB-GYNs, and addiction specialists.[7] Both methadone and buprenorphine treatment are endorsed by the American College of Obstetricians and Gynecologists and the American Society of Addiction Medicine as best practices for addressing opioid use during pregnancy.[4]

Methadone, a long-acting opioid agonist that decreases the desire to take opioids, was established as the standard of care in 1998 for treating OUD in pregnant women. The Substance Abuse and Mental Health Service Administration (SAMHSA) identified methadone as a safe drug to take while pregnant or preparing for pregnancy, along with counseling and participation in social support programs.[8]

Recently, The American Society of Addiction Medicine (ASAM) recognized Buprenorphine combined with Naloxone as the standard of care for the treatment of women who are pregnant or breastfeeding with OUD. The American Osteopathic Academy of Addiction Medicine (AOAAM) supports ASAM consensus that the combination of Buprenorphine and Naloxone is regularly used, safe, and effective.[9] Buprenorphine is the first medication to treat opioid use disorder that was authorized to be administered in physician offices, resulting in improved access to treatment.[10] Studies indicate that buprenorphine reduces fluctuations in fetal levels of opioids, minimizes repeated prenatal withdrawal, decreases overdoses, and limits drug interactions.[10]

Neonatal withdrawal, also called neonatal abstinence syndrome (NAS), is an anticipated and treatable condition caused by perinatal exposure to opioids, including methadone and the combination of buprenorphine with naloxone.[11] Although NAS may still occur in infants whose mothers receive MAT, the symptoms are milder than they would be without treatment.[4]

Postpartum, both infants and women on maintenance therapies can experience greater benefits through breast feeding. Although trace amounts of both methadone and buprenorphine have been found to seep into breast milk, research has shown that the benefits of breastfeeding outweigh the negligible risk associated with the medication that enters breast milk.[8, 10]

Breastfeeding

Because of the associated benefits, exclusive breastfeeding, without other supplementation, is recommended for healthy women by both the American Academy of Pediatrics and the World Health Organization for the first 6 months of life.[12,13] Breastfeeding contributes to attachment between a woman and her infant, encourages skin-to-skin contact.[11] The antibodies and hormones found in breast milk defend the infant's immune system against illness and lower the risk of asthma, leukemia, childhood obesity, lower respiratory infections, eczema, diarrhea, vomiting, and Sudden Infant Death Syndrome.[14] Breastfeeding also improves the health of mothers post-delivery, simultaneously, lowering potential risk for diabetes, breast cancer, and ovarian cancer. Breast milk is also easier for infants to digest and cost efficient for parents.[14]

The American Academy of Pediatrics (AAP) recommendation applies to women who take methadone or buprenorphine as well, without regard for dosage.[15] Breastfeeding among women who are opioid dependent is also encouraged by both, the American College of Obstetricians and Gynecologists (ACOG) and the American College of Osteopathic Obstetricians and Gynecologists (ACOOG), as long as the women are taking methadone or buprenorphine consistently, abstaining from illicit drugs, and have no underlying complexities or conditions, such as human immunodeficiency virus (HIV) and or Hepatitis C with open/bleeding and cracked nipples.[11] Additionally, The ACOOG supports the ACOG committee review that women in the post-partum period who return to using street drugs and are not on stable OUD therapy should restrain from breastfeeding.[16] After 6 months, the AAP recommends continuation of breastfeeding, alongside introduction of complementary foods during the first year of life.[12]

In spite of these endorsements, less than 25% of mothers exclusively breastfeed for 6 months in the United States.[12] Formula supplementation of breast milk is commonly utilized. Supplementation is reportedly associated with many side effects that can lead to adverse infant and maternal outcomes. Formula supplements can negatively impact the "maternal milk supply, the duration of exclusive breastfeeding, and the infant's gut microbiome; alteration of the neonatal gut environment can be responsible for mucosal inflammation and disease, autoimmunity disorders, and allergic conditions in both childhood and adulthood".[17]

The Centers for Disease Control and Prevention established the breastfeeding report card, which provides national data on breastfeeding rates, breastfeeding support indicators, and

breastfeeding practices.[12] The breastfeeding report card indicates that, in 2015, 83.2% of infants were breastfed starting at birth, 57.6% were still breastfed at some level at 6 months, and 35.9% at 12 months.[12] This data suggests that "the early postpartum period is a critical time for establishing breastfeeding, but mothers may not be getting the support they need from health care providers, family members, and employers to meet their breastfeeding goals".[12]

Uptake of breastfeeding is likely even lower among women with OUD. National Institute on Drug Abuse (NIDA) states that the rate of breastfeeding is normally "low" among mothers with OUD. Increased formal breastfeeding education, direct support for mothers, health care providers training on breastfeeding techniques, and peer support are all effective interventions that promote the start and sustainability of breastfeeding among mothers.[18]

Conclusion

Increasing rates of maternal opioid use during pregnancy and NAS are public health concerns. The utilization of MAT with methadone or buprenorphine has been approved as a safe mechanism for combatting opioid use during pregnancy and while breastfeeding.

Breastfeeding improves maternal and infant morbidity and mortality and decreases the impact of adverse health conditions. Breastfeeding infants who were exposed to opioids prenatally have the added advantage of lessening the impact of other conditions, such as NAS. Encouraging breastfeeding among mothers with exposure to opioids, who are undergoing MAT, is a significant step toward addressing OUD and NAS and improving maternal and child health. It shall be noted that the ACOOG and AOAAM supports the content of this paper and the policy recommendations outlined to encourage exclusive breastfeeding among mothers with a history of OUD.

American Osteopathic Association Policy

Given the research surrounding the positive impact of breastfeeding, the American Osteopathic Association adopts the following policy statements as its official position on breastfeeding among mothers with exposure to opioid use disorder in the United States:

1. The American Osteopathic Association (AOA) acknowledges that exclusive breastfeeding significantly improves maternal and infant health outcomes.
2. The American Osteopathic Association supports methadone and buprenorphine/naloxone assisted treatment as standards of care for addressing opioid use disorder during pregnancy and in the postpartum period.
3. The American Osteopathic Association (AOA) encourages exclusive breastfeeding among mothers with a history of Opioid Use Disorder (OUD), who are under physician care, actively engaged in a recovery program, on appropriate opioid agonists (methadone or buprenorphine), abstaining from illicit drugs, and who have no other contraindications, such as human immunodeficiency virus (HIV) infection and or Hepatitis C with open/bleeding and cracked nipples.
4. The American Osteopathic Association (AOA) recommends the use of counseling, coordination of care, and social support for mothers during pregnancy and breastfeeding in the postpartum period.

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Source: H452-A/20

Status: 2020 Adopted

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REFERRED SUNSET RESOLUTION: H-411 - A/2019: H413-A/14 Epidemic Terrorist Attack Victims, Government Responsibility of Health Care)

Policy Statement

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

Source: H453-A/20

Status: 2004; 2009 Reaffirmed as Amended; 2014 Reaffirmed; 2020 Adopted as Amended

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REFERRED SUNSET RESOLUTION: H429 A/14 Minorities, Underrepresented (URM) – Increasing Numbers of Applicants…

Policy Statement

The American Osteopathic Association encourages an increase in the total number of URM1 graduates from colleges of osteopathic medicine by the year 2020 and encourages an increase in the total number of URM faculty by the year 2025.

Source: H454-A/20

Status: 2014; 2020 Adopted as Amended

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REFERRED RESOLUTION: Regulation of E-Cigarettes and Nicotine Vaping

Policy Statement

The following policy paper and the recommendations provided within be adopted as the amended policy of the AOA.

REGULATION OF E-CIGARETTES AND NICOTINE VAPING

BACKGROUND

The adverse health effects associated with tobacco use are well documented public health concerns. Smoking can damage every human organ, and it can lead to death from heart disease, cancers or strokes. According to the World Health Organization (WHO), 1 in 10 deaths each year, or nearly 8 million deaths around the world, are caused by tobacco use.[1,2] More than 7 million of those deaths are the result of direct tobacco use, while around 1.2 million are the result of non-smokers being exposed to second-hand smoke.[2] In the United States, this translates to 480,000 deaths per year from cigarette smoking and second-hand smoke exposure.[3]

In response to the negative health effects of tobacco products and cigarettes in particular, a natural market for smoking cessation and reduction products has emerged over the past 4 decades.[4] The use of electronic nicotine delivery systems (ENDS), such as electronic cigarettes (e-cigarettes), has reached a rapidly expanding consumer base.[5] E-cigarettes are often used or promoted to reduce consumption of tobacco products.[6] Alternative strategies for reaching smoking cessation goals include switching to low or light cigarettes or using nicotine-infused chewing gum, lozenges, lollipops, dermal patches or hypnosis.[7]

In the US, e-cigarettes are the most frequently utilized tobacco product among youth, who are also more likely than adults to use them. In 2019, over 5 million US middle and high school students had used e-cigarettes in the past 30 days.[8] In 2018, 3.2% of US adults were current e-cigarette users.[9]

The name e-cigarette is an umbrella term that includes any battery-powered device that vaporizes liquid nicotine for delivery via inhalation. These devices are most commonly referred to as electronic cigarettes, e-cigarettes, e-cigs, vaping, vape pens, vape pipes, hookah pens, e-hookahs, but could potentially be referred to by other terms. Since its 2007 introduction in the United States, the e-cigarette market has grown to include more than 460 brands.[10] E-cigarettes are a 2.5 billion dollar business in the United States.[11] The attraction to e-cigarettes crosses many segments of the population, appealing to tobacco cigarette smokers trying to quit as well as non-smokers who want to try nicotine without the harmful additives.[12] Though some states and municipalities have started to ban e-cigarettes, tobacco cigarette smokers can use e-cigarettes as a source of nicotine in some venues where conventional cigarettes are banned.

Costs associated with smoking-related illnesses continue to escalate. In 2014, smoking-related illness costs in the United States were more than $300 billion each year, including approximately $170 billion for direct medical care for adults, and more than $156 billion in lost

productivity. Nearly $5.6 billion of the lost productivity cost was due to secondhand smoke exposure.[13]

Overall, e-cigarettes may be less harmful for heavy or moderate smokers because they may reduce exposure to carcinogens and other toxic chemicals that cause serious disease and death.[14] However, the effect of long term consumption of nicotine and associated aerosols remains unclear. Studies have shown that e-cigarette vapors may be harmful, particularly in places with limited ventilation and for people with compromised health. Furthermore, e-juice liquids have been found to increase accidental poisonings in children. The full scale of health and safety hazards of vaping for users and secondhand users is undetermined.[15]

ANALYSIS

Regulation of e-cigarettes by the Food and Drug Administration (FDA) only began in earnest in 2016. The Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act) provided the FDA authority to regulate the manufacture, marketing and distribution of tobacco products.[16] However, e-cigarettes were not initially included in the FDA's regulation of tobacco products. Unlike tobacco cigarettes, e-cigarettes have enjoyed the ability to advertise on television and radio.[17] This allows e-cigarette companies to market their product in a more liberal fashion in response to market demands, including the use of celebrity endorsements.[18] However, some manufacturers have voluntarily begun to limit their advertising in an attempt to avoid federally imposed restrictions on advertising.

The Composition of E-Cigarettes

The e-cigarette is a smokeless, battery-powered device that vaporizes liquid nicotine for delivery via inhalation.[19] Using an e-cigarette may also be referred to as "vaping", or as "juuling", the branded form of flavored e-cigarettes popular among younger consumers. The e-cigarette contains nicotine derived from tobacco plant and several secondary chemical ingredients.[20] It is primarily composed of a nicotine cartridge, atomizer, and a battery.[21] The atomizer, which converts the nicotine liquid into a fine mist, consists of a metal wick and heating element.[22] When screwed onto the cartridge, the nicotine liquid from the cartridge, which could also include flavoring, comes into contact with the atomizer unit and is carried to the metal coil heating element.[23] A single cartridge can hold the nicotine equivalent of an entire pack of traditional cigarettes.[24] E-cigarettes can also be used to deliver marijuana and other drugs.[25]

While the typical e-cigarette is sold in the shape of a cigarette, many products are sold in the shape of discreet objects such as pipes, pens, lipsticks, and other everyday items.[26] Often, they can be legally used where traditional tobacco products are banned.

Federal Efforts to Regulate

In 2016, the FDA finalized a rule extending regulatory authority to cover all tobacco products, including electronic nicotine delivery systems (ENDS) that meet the definition of a tobacco product.[27] The FDA now regulates the manufacture, import, packaging, labeling, advertising, promotion, sale, and distribution of ENDS. Prior to this rule, the FDA could regulate e-cigarettes only if the manufacturer made a therapeutic claim, such as the product was being marketed as a cessation device.[28]

The rule established restrictions on youth access to newly regulated tobacco products by: (1) banning their sale to individuals younger than 18 years of age (federal legislation raised this to 21 years in 2019) and requiring age verification via photo ID; and (2) prohibiting the sale of tobacco products in vending machines (unless in an adult-only facility).[29]

The Federal Food, Drug, and Cosmetic Act was signed into law on December 20, 2019, and raised the federal minimum age of sale for tobacco products from 18 to 21 years.[30] Retailers are now prohibited from selling tobacco products to anyone under the age of 21.

Further, in January 2020, the FDA banned all mint- and fruit-flavored e-cigarettes, but exempted menthol- and tobacco-flavored products, in an effort to target products widely used by minors while preserving an "off-ramp" for adults who are trying to quit smoking.[31]

Tobacco is a major threat to public health, and one of the goals of the FDA is to protect Americans from tobacco-related diseases and death. This rule allows the FDA to protect youth by restricting their access to tobacco products, helps consumers better understand the risks of using these products, prohibits false and misleading product claims, and prevents new tobacco products from being marketed unless a manufacturer demonstrates that the product meets relevant public health standards.

State Efforts to Regulate

Various states and municipalities have also enacted laws restricting the sale of e-cigarettes.[32] Twenty-seven states, along with the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, and 1,107 municipalities have passed laws that ban smoking in all non-hospitality workplaces, restaurants, and bars; of these, 22 states and 929 municipalities also restrict e-cigarette use in 100% smoke-free venues.[33]

In November 2019, **Massachusetts** became the first state to restrict the sale of *all* flavored tobacco products, including e-cigarettes and menthol cigarettes.[34] **New Jersey** prohibited the use of e-cigarettes in all enclosed indoor places of public access as well as in working places, and in January 2020, the state enacted legislation banning the sale of *all* flavored e-cigarettes.[35,36] In March 2020, **Rhode Island** also announced a permanent ban on the sale of flavored e-cigarettes.[37] Six other states (Michigan, Montana, New York, Oregon, Utah and Washington) temporarily banned the sale of flavored e-cigarettes in 2019, but of those, only Montana's and Washington's bans are currently in effect while the others are facing various legal challenges.[38]

As of 2019, twenty-three (23) states and the District of Columbia have enacted statutes which require licenses for retail sales of e-cigarettes.[39]

Arguments for E-Cigarettes

Proponents of e-cigarettes consider e-cigarettes to be less harmful than traditional tobacco products and believe they increase adult smoking cessation.[40] While it has been established that e-cigarettes contain fewer carcinogenic elements than traditional tobacco cigarettes, the long-term health effects of e-cigarette use are unknown.[41] According to the American Lung Association there are approximately 600 ingredients in cigarettes.[42] When burned, they create more than 7,000 chemicals.[43] At least 69 of these chemicals are known to cause cancer, and many are poisonous.[44] While e-cigarettes may have fewer component chemicals, a study found that the usage of e-cigarettes contributes to indoor air contamination.[45] A 2016 report from the WHO determined that second-hand aerosols from e-cigarettes are a new source of pollution for hazardous particulate matter (PM). The levels of nickel, chromium, and other metals found in second-hand aerosols are higher than ambient air and higher than second-hand tobacco smoke.[46]

The greatest appeal of e-cigarettes for smoking cessation is that they deliver nicotine to alleviate nicotine withdrawal symptoms. E-cigarettes evoke the psychological response to

cigarette smoking because of its shape and the familiar behavior aspect of smoking.[47] A 2011 survey of 104 e-cigarette users revealed that 66% started using them with the intention to quit smoking and almost all felt that the e-cigarette had helped them to succeed in quitting smoking.[48] Another survey of 3,037 e-cigarette users revealed that 77% of respondents used e-cigarettes to quit smoking or to avoid relapse.[49] None said they used them to reduce consumption of tobacco with no intent to quit smoking.[50] However, the overall effectiveness of e-cigarettes is still in question. In a randomized study, participants given e-cigarettes, nicotine patches and placebo e-cigarettes that lacked nicotine were able to quit smoking at roughly the same rates, with insufficient statistical power to conclude superiority of nicotine e-cigarettes.[51]

Consequences of E-Cigarettes

Advocates of e-cigarettes contend that e-cigarettes are less risky than traditional tobacco products and can serve as a mode of harm reduction by reducing smoking or serving as a smoking cessation strategy.[52] While there is limited evidence that suggests that adult smokers could benefit from e-cigarette use instead of combustible tobacco products, smokers would need to fully switch to e-cigarettes and stop smoking cigarettes and other tobacco products completely to achieve any meaningful health benefits from e-cigarettes. Experts who serve on the US Preventive Services Task Force have resolved that there is insufficient evidence to recommend e-cigarettes for smoking cessation in adults, including pregnant women. Thus, e-cigarettes are not currently approved by the FDA as an aid to quit smoking.[53]

Another major concern is that e-cigarettes appeal to youth by being flavorful, trendy and a convenient accessory.[54] The flavorings being used, such as candy and other sweet flavorings are particularly attractive to younger populations. For this reason, these flavorings are banned in traditional cigarettes.[55] Despite a downturn prior to 2017, e-cigarette use among youth has drastically increased. From 2017 to 2018, the percent of middle school students who used e-cigarettes increased 48%, resulting in 570,000 middle school students, or 4.9%, who were current e-cigarette users. Among high school students during the same period, current e-cigarette use, defined as use at least one day in the past 30 days, increased by 78%, from 11.7% to 20.8%, the equivalent of 3.05 million high school students using e-cigarettes in 2018. Current e-cigarette users in high school who reported use on 20 days or more in the past 30-day period increased from 20% to 27.7%. During the same timeframe, use of flavored e-cigarettes increased among high school students who currently used e-cigarettes as well. Use of any flavored e-cigarette went up among current users from 60.9% to 67.8%, and menthol use increased from 42.3% to 51.2% among all current e-cigarette users, including consumers of multiple products, and from 21.4% to 38.1% among those using only e-cigarettes. From 2018 to 2019, the number of middle school and high school students who reportedly used e-cigarettes in the past 30 days increased from a total of 3.6 million to 5.4 million youth.[56]

In addition to exposure to the carcinogenic and toxic effects of tobacco, smokers become addicted to the nicotine.[57] Nicotine addiction is characterized as a form of drug dependence recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V).[58] E-cigarette cartridges can contain up to 20 times the nicotine of a single cigarette, and the process of vaping lacks the normal cues associated with cigarette completion, such as the butt of the cigarette ending a dose.[59]

Conditioning has a secondary role in nicotine addiction. Smokers associate particular cues with the high of smoking, often causing relapse when those seeking to quit smoking are confronted with those cues.[60] E-cigarettes allow quitting smokers to respond to those cues. This poses a risk of overconsumption. The lack of finality to an e-cigarette is determined only by the battery or

nicotine cartridge. Distinguishable from tobacco cigarettes, smokers who have turned to the e-cigarette no longer have the butt of the cigarette as a cue to stop smoking.[61]

E-cigarettes can cause other inadvertent injuries as well. The CDC, the US Food and Drug Administration (FDA), state and local health departments, and other clinical and public health organizations have investigated a national outbreak of e-cigarette, or vaping, product use-associated lung injury (EVALI).[62] EVALI is an inflammatory response in the lungs triggered by inhaled substances. EVALI has been found to vary due to the substantial variety of products and ingredients used. It may present as pneumonia or an inflammatory condition known as fibrinous pneumonitis.[63] As of February 2020, 2,807 hospitalized EVALI cases or deaths were reported to CDC from all 50 states, the District of Columbia, Puerto Rico and U.S. Virgin Islands. Sixty-eight (68) deaths were confirmed in 29 states and the District of Columbia. Vitamin E acetate, an additive in some THC-containing e-cigarette products, was found to be strongly associated with the EVALI outbreak.[64]

Additionally, e-cigarettes are manufactured from metal and ion components that introduce concerns about faulty products and malfunctions.[65] Defective e-cigarette batteries have caused fires and explosions, some of which have resulted in serious injuries. Lithium-ion batteries have reportedly overheated, caught fire or exploded, an event known as thermal runaway. From 2015 to 2017, an estimated 2,035 e-cigarette explosions and burn injuries presented to hospital emergency departments. Although the explosions are relatively rare, they can cause severe injuries.[66]

CONCLUSION

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

The AOA supports FDA and state regulation prohibiting sales and advertisements of electronic cigarettes to persons under the age of 21. Advertisements for electronic cigarettes should be subject to the same rules and regulations that are enforced on traditional cigarettes.

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

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

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

The AOA encourages physicians to educate patients about the risks of e-cigarette use, and to counsel patients to submit voluntary reports to the US Department of Health and Human Services Safety Reporting Portal (www.safetyreporting.hhs.gov) if they sustain adverse reactions to e-cigarettes.

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Source: H455-A/20

Status: 2020 Adopted as Amended

AMERICAN
OSTEOPATHIC ASSOCIATION

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Support Nutritionally Balanced, Low Cost or Free Meals for Children in Schools

Policy Statement

The American Osteopathic Association (AOA) advocates for legislative efforts in support of widely accessible, nutritionally-balanced, low-cost or free meals for all children in the U.S. Pre-K through 12 schools.

Source: H400-A/21

Status: 2021

AMERICAN
OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
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Supporting Public Policy to Encourage Wholesome Food Donations to those in Need in America

Policy Statement

The American Osteopathic Association (AOA) stands in support of our current public policy that increases access to food for all Americans. The AOA supports increasing access to donations of wholesome food through the use of qualified food banks.

Source: H401-A/21

Status: 2021

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OSTEOPATHIC ASSOCIATION

142 E. Ontario St.
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Collection of Public Health Data Concerning Firearm Fatalities

Policy Statement

The American Osteopathic Association (AOA) supports the collection of public health data concerning firearm fatalities. The data points to be collected should be separated into the following categories: homicides, including the number of domestic violence homicides; suicides and accidents; and non-fatal firearm related injuries. Within each category, the ages of the victims to be noted.

Additional data to be collected is the hospitalizations that occurred as a result of a firearm that did not result in death and include the caliber of the firearm used.

The AOA will advocate to make this data publicly available and develop healthcare guidance and inform public policy.

Source: H402-A/21

Status: 2021

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Patient Centered Treatment for Pain Management and Appropriate Use of Opioids

Policy Statement

The American Osteopathic Association (AOA) support increased access to evidence-based pharmacotherapy for treatment of chronic pain, with a lens that places value on the functional status of the patient rather than the Milligram Morphine Equivalent (MME) of the prescription. The AOA will continue to support risk management in terms of toxicology monitoring, volume prescribed, and the use of the Prescription Monitoring Program (PMP) and the AOA will continue to promote referral for patient centered treatment when a SUD is diagnosed.

Source: H403-A/21

Status: 2021

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Improving Outcomes in Behavioral Health Care in the Emergency Department

Policy Statement

The American Osteopathic Association (AOA) supports innovative models that increase availability of emergency behavioral health care for crisis stabilization.

Source: H410-A/21

Status: 2021

AOA Firearm Policy Compendium

Introduction

The American Osteopathic Association (AOA) is dedicated to reducing the impact of violence on health and wellness in our communities, including injury and death that result from firearm violence. As physicians, we see firsthand the consequences of violence to victims and their families. The AOA recognizes that laws, regulations, and policies have the potential to decrease the occurrence of violence, especially firearm violence, in our communities.

The 2019 AOA House of Delegates (HOD) adopted a resolution, H437-A/19, Firearm Violence, which states that the AOA *"will develop a comprehensive policy which consolidates all current firearm violence policies into a single unified policy and present it for consideration by the 2020 AOA House of Delegates."* In response to the adoption of this policy, the Bureau on Federal Health Programs (BFHP) concluded that having a broad array of policies on a given topic allows AOA staff to accurately respond to federal and regulatory concerns. With nuanced policy to reference, the bureau determined that the best approach to implementing this policy is to develop a comprehensive document that includes all current AOA policies relating to firearm violence. This approach is also intended to preserve any relevant background and history of individual resolutions and avoid any potential impediments to future policy changes.

The BFHP submitted a white paper to the 2020 HOD in response to the direction provided in H437-A/19 that included an overview of AOA firearm policy through 2019. Questions were raised by delegates at the 2020 HOD regarding the scope of the document submitted and whether more current data was available, and it subsequently was referred back to the BFHP. In response to this referral, the BFHP has updated its research; firearms resolutions adopted by the 2020 HOD along with updated federal statistics and citations are included in this compendium.

Background

Much of the AOA's policy is predicated on an understanding of the role of firearms on public health in the United States. According to the Centers for Disease Control and Prevention (CDC), firearm-related deaths in the U.S. reached a twenty year high in 2017[i]. In 2018, there were 39,740 firearms-related deaths in the U.S., with 109 people dying from firearm-related injury each day[ii]. The CDC estimates that 6 in 10 of these are suicide and 3 in 10 are homicide[iii]. Additionally, in 2018, more U.S. deaths were attributed to firearms than motor vehicle accidents[iv].

An analysis of 2010 data showed that the U.S. had the highest rate of firearm-related violence, suicides, and accidents among industrialized countries[v]. Beyond the impact on the health and well-being of Americans, there is an economic impact, with gun violence in the U.S. costing $229 billion in 2015[vi].

Policies Preserving the Ability of Physicians to Educate and Counsel their Patients on Firearm Violence

Preserving the rights of physicians and other health care professionals to counsel patients on prevention, including the prevention of injury or death, as a result of firearms is critical. Physicians play an important role in preventing firearm injuries through health screenings, patient counseling, and referral to mental health services.

Current Resolutions on Firearm Education:

- **H425-A/19 FIREARM SAFETY**
  The American Osteopathic Association (AOA) recommends that when appropriate, physicians ask patients and/or caregivers about the presence of firearms in the home and counsel patients who own firearms about the potential dangers inherent in gun ownership, especially if vulnerable individuals, children and adolescents are present. The AOA recommends strategies such as secure storage and the use of safety locks to eliminate the inappropriate access to firearms by vulnerable individuals, children and adolescents and recommends all physicians educate families on the safe use and storage of firearms. 1994; revised 1999, 2004; reaffirmed 2009; 2014; reaffirmed as amended 2019

- **H418-A/20 FIREARMS AND NON-POWDERED GUNS – EDUCATION FOR USERS**
  The American Osteopathic Association supports education involving firearm and non-powdered guns safety and the inherent risk, benefits and responsibility of ownership. 1990; reaffirmed 1995, 2000, 2005; revised 2010; revised 2015; adopted as amended 2020
  [Editor's Note: Non-powdered guns are defined as: BB, air and pellet guns, expelling a projectile (usually made of metal or hard plastic) through the force of air pressure, CO2 pressure, or spring action. Non-powder guns are distinguished from firearms, which use gunpowder to generate energy to launch a projectile.]

- **H340-A/16 PHYSICIAN GAG RULES – OPPOSITION TO**
  The American Osteopathic Association (AOA) is opposed to governmental actions and policies that limit the rights of physicians and other health care practitioners to inquire of their patients whether they possess guns and how they are secured in the home or to counsel their patients about the potential dangers of guns in the home and safe practices to attempt to avoid those potential dangers. The AOA opposes any further legislation or initiatives advocating physician gag rules that limit physicians' right to free speech or other rights. 2016

- **H428-A/19 PHYSICIAN-PATIENT RELATIONSHIP AS RELATED TO PROPOSED GUN CONTROL LAWS, PROTECTION OF THE**
  While the American Osteopathic Association supports measures that save the community at large from gun violence, the AOA opposes public policy that mandates reporting of information regarding patients and gun ownership or use of guns except in those cases where there is duty to protect, as established by the Tarasoff ruling, for fear of degrading the valuable trust established in the physician-patient relationship. 2013; reaffirmed 2019

Policies on Advancing Research to Reduce Firearm Violence

Advancing research to reduce firearm violence is a public health issue that deserves the allocation of appropriate resources. The AOA supports funding for the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and other research entities, to conduct research on firearm violence and to provide recommendations on reducing firearm violence.

Current Resolutions on Firearm Research:

- **H442-A/20 FIREARM VIOLENCE**
  The American Osteopathic Association (AOA) (1) supports the federal government's January 2013 clarification, "that no federal law in any way prohibits doctors or other health care providers from reporting their patients' threats of violence to the authorities, and issuing guidance making clear that the Affordable Care Act does not prevent doctors from talking to patients about gun safety"; (2) supports funding for the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and other research entities to conduct research on firearm violence and to provide recommendations on reducing firearm violence; (3) supports promotion of policies that will increase access to mental health services and for the appropriate coverage of mental health services by public and private health care programs; and (4) encourages enhanced education of gun safety and safe handling of firearms; and (5) approves the attached Policy Statement on Firearm Violence. 2013; revised 2015; adopted as amended 2020

AOA Policy Statement – Firearm Violence

The American Osteopathic Association (AOA) is dedicated to preventing violence in our communities, especially the increased prevalence of firearm violence. As physicians, we see first-hand the devastating consequences of violence to victims and their families. The AOA recognizes that laws, regulations, and policies have the potential to decrease the occurrence of violence, especially firearm violence, in our communities. The AOA supports:

<u>Preserving the Ability of Physicians to Educate and Counsel their Patients on Firearm Violence</u>

Preserving the rights of physicians and other health care professionals to counsel patients on prevention, including the prevention of injury or death as a result of firearms, is critical. Physicians play an important role in preventing firearm injuries through health screenings, patient counseling, and referral to mental health services. The AOA supports the administration's January 2013 clarification, "that no federal law in any way prohibits doctors or other health care providers from reporting their patients' threats of violence to the authorities, and issuing guidance making clear that the Affordable Care Act does not prevent doctors from talking to patients about gun safety." We must ensure that no federal or state law hinders, restricts, or criminalizes the patient-physician relationship.

Advancing Research to Reduce Firearm Violence

Advancing research to reduce firearm violence is a public health issue that deserves the allocation of appropriate resources. The AOA supports funding for the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and other research entities to conduct research on firearm violence and to provide recommendations on reducing firearm violence.

Improving Access to Mental Health Services and Resources

Improving access to mental health services and resources is essential to reducing firearm violence. The AOA supports promotion of policies that will increase access to mental health services and for the appropriate coverage of mental health services by public and private health care programs. Access to mental health services and resources for young adults should be a priority. The early identification of diagnosable mental health issues and subsequent treatment is vital to reducing firearm violence.

- **H630-A/18 COMPREHENSIVE GUN VIOLENCE REFORM**
  The American Osteopathic Association joins like-minded organizations in the call for Congressional legislation that:

    1. Labels gun violence as a national public health issue.
    2. Funds appropriate research on gun violence as part of future federal budgets.
    3. Establishes constitutionally appropriate restrictions on the manufacturing and sale, for civilian use, of large-capacity magazines and firearms with features designed to increase their rapid and extended killing capacity. 2018

Additional Policies Supporting Reduced Firearm Injury

- **H318-A/16 FIREARMS – COMMISSION OF A CRIME WHILE USING A FIREARM**
  The American Osteopathic Association supports the position that persons accused of a crime involving a firearm be prosecuted to the full extent of the law. 1994; revised 1996, 2001; reaffirmed 2006; reaffirmed as amended 2011; reaffirmed 2016
- **H446-A/20 BACKGROUND CHECKS AND FIREARMS SAFETY TRAINING AS A CONDITION OF FIREARMS PURCHASE**
  The American Osteopathic Association (AOA) recognizes public health data demonstrating the impact of firearms on mortality and wellness in the United States and will support federal legislation requiring comprehensive background checks for all firearm purchases, including sales by gun dealers, sales at gun shows, and online sales for purchase, which does not extend to firearms transfers between family members or firearms attained through inheritance; and the AOA will support efforts to require firearms safety training, including military or law enforcement training, as a condition to purchase any class of firearms. H421-A/15 is superseded by this resolution. adopted 2020

Conclusion

As noted above, the AOA House of Delegates adopted a policy in 2019 that calls for the identification of all current firearm violence policies in a single document. This compendium reflects that policy and highlights the wide range of issues addressed in AOA firearm policies which includes eight individual policies. At least two resolutions (H425-A/19 and H418-A/20) support education and recommend safety precautions for gun owners. One (H340-A/16) opposes any governmental action that would limit the right of physicians to discuss with their patients the topic of responsible gun ownership and safe storage. Another (H428-A/19) opposes any mandated reporting of patient gun ownership. Two policies (H442-A/20 and H630-A/18) support federal funding for research on firearm violence. H630-A/18 also labels gun violence as a national public health issue and supports federal legislation that would establish constitutionally appropriate restrictions on the manufacturing and sale of certain classes of firearms. Lastly, H446-A/20 supports federal legislation requiring comprehensive background checks for firearms as well as efforts to require firearm safety training.

There is a separate and distinct focus in most of these policies, with covered issues ranging from education, to protecting the rights of physicians, support for research, and support for certain restrictions on sales. As such, these policies, as well as any future firearm-related policies, should be maintained and taken up for review and reconsideration by the House of Delegates on an individual basis.

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[i] Center for Disease Control and Prevention. WONDER Database. Underlying Cause of Death, 1999 – 2017.

[ii] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2019 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html

[iii] Id.

[iv] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2019 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html

[v] Grinshteyn E, Hemenway D. Violent Death Rates: The US Compared with Other High-Income OECD Countries, 2010. Am J Med. 2016;129:266-73.

[vi] Follman M, Lurie J, Lee J, West J. The True Cost of Gun Violence in America. 15 April 2015.

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Drug Samples

Policy Statement

The American Osteopathic Association (1) encourages the pharmaceutical industry to continue the distribution of drug samples, and/or vouchers to physicians, including those drugs whose patents have expired, (2) will petition the Food and Drug Administration to not limit the manufacturers' distribution of drug samples and/or vouchers; and (3) will continue to defend and support policies that allow osteopathic physicians to provide drug samples (including stock bottles or vouchers when appropriate) free-of-charge to patients.

Source: H412-A/21

Status: 1995; 1996 Reaffirmed; 2001 Revised; 2006 Reaffirmed; 2011 Reaffirmed; 2016 Reaffirmed; 2021 Reaffirmed

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Concussion, Return-to-Play and Return-to-Learn

Policy Statement

The American Osteopathic Association (AOA) approves the Youth Concussion and Return-to-Play white paper and its position on concussion, return-to-play and return-to-learn.

Source: H413-A/21

Status: 2016; 2021 Reaffirmed as Amended

Youth Concussion and Return-To-Play White Paper

Since 2009, every state has passed some form of legislation to address concussion safety in youth athletics. Most states' laws address the following five common areas:

1. Parent and student education,
2. Parent and student signature requirements,
3. Coach training, removal and return-to-play [RTP],
4. Return-to-learn [RTL] and
5. Clearing provider types

State laws vary, however, in the precise degree of detail and rigor of their respective requirements. The American Osteopathic Association (AOA) is committed to helping states work to address this public health risk by providing evidence-based guidance on concussion as a part of the spectrum of Traumatic Brain Injuries (TBIs), as well as RTP and RTL protocols for youth athletes. We support policies that are backed by current scientific evidence, with appropriate clarification regarding the definitions of terms and protocols. The AOA believes that allopathic and osteopathic physicians (MDs and DOs) possess the complete medical knowledge and training needed to recognize and diagnose the subtle, varying and evolving symptoms of concussion, but that coordination across all levels of the physician-led team is imperative for timely evaluation and intervention, and appropriate follow-up care. In order to ensure the appropriate level of care, team physicians should possess up- to-date documentation of knowledge, skills and experience in this area of medicine. The goal of this paper is to encourage greater consistency among the terminology used by health care organizations, and to utilize current evident to help states create a standardized approach to concussion, RTP and RTL.

Background

In recent years, a consensus has emerged among the scientific community that head injuries resulting from contact sports, including football, soccer, boxing, ice hockey and others, can have devastating long-term effects.[1] Among the consequences of repeated head injuries are headache, dizziness, difficulty concentrating or completing tasks, and in some cases, increased risk of depression and suicide.[2] Children and teenagers are especially susceptible to concussion-related injuries, because their brains lack the coating and insulation of adult brains and their heads are relatively heavy, and necks weak, compared to adults.[3] Thus, children are at risk of sustaining more serious brain injuries than adults when exposed to the same amount of force. According to the CDC, the number of TBI-

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[1] McCrory, Paul, Meeuwisse, Willem H., Aubry, Mark, et al. "Consensus Statement on Concussion in Sport: the 4th International Conference on Concussion in Sport held in Zurich, November 2012." *British Journal of Sports Medicine,* 2013;47:250-258. Available at: http://bjsm.bmj.com/content/47/5/250.full

[2] No author. "Long-term Effects of Brain Injuries." *Weill Cornell*, no date. Available at: http://weillcornellconcussion.org/about-concussions/long-term-effects-brain-injuries.

[3] No author. "Parents Vigilance Can Head Off Kids' Concussion Risk." *USA Today*, Sept. 29, 2012. Available at: http://www.usatoday.com/story/news/nation/2012/09/29/concussion-kids-cantu/1581173/.

related emergency department visits among youth doubled from 2002 to 2010, from approximately 500 to 1,000 per 100,000 people.[4] Further, female athletes appear to be more susceptible to sustaining concussions than males.[5]

To address this issue, all states have now implemented some form of concussion and RTP legislation. The National Center for Injury Prevention and Control (NCIPC) conducted a case study on two states that were early implementers of these laws, Washington and Massachusetts, to evaluate differences in their laws and approaches to addressing youth sports-related injuries.[6]

Washington became the first state to implement a concussion law with the passage of the "Zackery Lystedt Law" in May 2009.[7] This law mandates that youths suspected of having sustained a head injury or concussion should be removed from competition, and returned to play *only* after an evaluation and written medical clearance from a "licensed health care provider* trained in the evaluation and management of concussion."[8] The law requires individual school districts to develop information to educate youth athletes, their parents and coaches about the nature and risk of concussions, but it does not provide any specific requirements for the content of those guidelines. The law does not require any coach training, and students are not required to complete concussion history forms.

Massachusetts' law, by contrast, requires stakeholder groups including parents, coaches, trainers, school athletic directors and school-employed physicians and nurses to participate in an athletic head injury safety training program developed by the Department of Public Health.[9] It directs the Department to utilize materials from the Centers for Disease Control and Prevention to create the program, which shall include (1) current training in recognizing the symptoms of concussions and

(2) providing students who participate in athletic activities a summary of the medical protocol for recognizing concussion symptoms, a protocol for post-concussion participation in athletics, and the short- and long-term consequences of concussions. It requires schools to implement an RTP protocol containing 17 specific items including procedures for medical review of all concussion history forms and plans for gradual RTP following injury. It also mandates that schools establish their own RTP protocol implementation teams. The law requires students to provide information about their concussion and head injury history at the start of each sports season on a form that must be signed by the student and their parent or guardian and forwarded to their coach(es). A student who becomes unconscious or is suspected of having suffered a concussion must be

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[4] No author. "Rates of TBI-related Emergency Department Visits by Age Group — United States, 2001–2010." *Centers for Disease Control and Prevention*, no date. Available at: http://www.cdc.gov/traumaticbraininjury/data/rates_ed_byage.html.

[5] Franks, R. Robert. "Why are Concussions Worse in Females? " *Philly.com*, Apr. 12, 2013. http://www.philly.com/philly/blogs/sportsdoc/Why-are-concussions-worse-in-females.html.

[6] No author. "Implementing RTP: Learning from the Experiences of Early Implementers." *National Center for Injury Prevention and Control*, no date. Available at: http://www.cdc.gov/headsup/pdfs/policy/rtp_implementation-a.pdf.

[7] No author. "Youth Sports—Concussion and Head Injury Guidelines." Revised Code of Washington 28A.600.190 (2009). Available at: http://apps.leg.wa.gov/rcw/default.aspx?cite=28A.600.190.

[8] *Id*.

[9] No author. "Interscholastic Athletic Head Injury Safety Training Program." Massachusetts General Laws 111 §222 (2010). Available at: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section222.

* Licensed Health Care Provider is undefined by the law, and may be a volunteer.

removed from practice or competition and not returned to the practice or competition during which the concussion or suspected concussion occurred. The student may only return to subsequent athletic activities with the written clearance of a physician, neuropsychologist, certified athletic trainer or other "appropriately trained or licensed health care professional as determined by the Department of Public Health."

Numerous state laws in addition to Massachusetts' include athletic trainers and nurses among the "clearing provider types" who may allow a youth to return to athletic activity following a concussion. Forty-nine states (with the exception of California) license and regulate athletic trainers, and all require that certified athletic trainers work within their state practice act under the direction of a physician. All forty-nine states recognize certification by the National Athletic Trainers' Association, which will soon increase the minimum education required for certification from a bachelor's degree to a master's degree from an accredited professional athletic training education program.[10] Graduates must then pass a comprehensive examination, and meet ongoing continuing education requirements. Education programs include training in the identification of signs, symptoms, interventions and RTP criteria for brain injury including concussion, but continuing education requirements vary widely (some states require concussion management as a part of these continuing education requirements, while others do not).[11, 12, 13]

While all states license and regulate nurses, nursing education varies more widely and concussion education is not mandatory. The National Association of School Nurses (NASN) recommends a four-year bachelor's degree and registered nurse (RN) certification as the minimum standard for a school nurse.[14] The NASN has issued a position statement on the importance of the school nurse on the concussion management team; however, the RN examination does not include concussion among the list of topics and not all states require continuing education for nurses.[15, 16] As athletic trainers and school nurses are frequently on the front lines of youth concussion evaluation and management, more robust state education and training requirements are needed to ensure that these health care professionals receive current, evidence-based training in this area, particularly when these providers are listed among the state's "clearing provider types."

Washington and Massachusetts' laws illustrate the wide variation in approaches that states have taken to attempt to address concussion among student athletes, and while all 50 states now possess similar laws, these laws differ significantly in their provisions. Several physician specialty organizations have examined this issue, and published position statements which include evidence- based guidance for states.

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[10] No author. "After 2.5 Years of Diligent Analysis, Leaders of the Key Athletic Training Organizations Have Decided to Change the AT Degree Level to a Master's." *AT Strategic Alliance*, May 20, 2015. Available at: http://atstrategicalliance.org/statements/strategic-alliance-degree-statement.

[11] No author. “Athletic training education competencies (5th edition).” *National athletic trainers’ association*, released 2011. Available at: https://www.nata.org/sites/default/files/competencies_5th_edition.pdf.

[12] No author. “Continuing education requirements for athletic trainers.” *Texas department of licensing and regulation*, no date. Available at: https://www.tdlr.texas.gov/at/atce.htm#renew.

[13] No author. “Current rules and regulations.” *Wyoming athletic training board*, april 16, 2020. Available at: https://rules.wyo.gov/search.aspx?agency=065&program=0001.

[14] No author. “Education, Licensure, and Certification of School Nurses: Position Statement.” National Association of School Nurses, Jan. 2012. Available at: https://www.nasn.org/advocacy/professional-practice-documents/position-statements/ps-education.

[15] No author. “NCLEX-rn® examination.” *national council of state boards of nursing*, effective April 2013. available at: https://www.ncsbn.org/2013_nclex_rn_test_plan.pdf.

[16] No author. “state ce requirements for licensure.” *medscape*, march 29, 2021. available at: https://www.medscape.org/public/nursecestaterequirements.

The American Osteopathic Academy of Sports Medicine (AOASM), as a contributing author on the 2013 paper *Concussion and the Team Physician: A Consensus Statement (TPCC)*, which is still current, advocated for on-field and sideline protocols such as neurological assessments and a plan for post-injury follow-up, as well as post-game-day evaluation and treatment.[17] AOASM, via the *TPCC*, urged guidelines that encourage individualized RTP decisions not based on a rigid timeline, with the physician ultimately bearing responsibility for making the decision. The paper also advocates that treating physicians should understand the complications of concussion, including that cumulative concussions may increase subsequent risk for concussion, and other neurological and physical symptoms. Physicians should also understand prevention principles, including helmet use and the utility of educating athletes, parents and coaches about concussion risks in advance.

The Centers for Disease Control and prevention (CDC) published guidelines on the diagnosis and management of mild traumatic brain injury among children in 2018.[18] “recommendations from the CDC pediatric TBI guidelines include:

1. Do not routinely image patients to diagnose TBI.
2. Use validated, age-appropriate symptom scales to diagnose TBI.
3. Assess evidence-based risk factors for prolonged recovery.
4. Provide patients with instructions on return to activity customized to their symptoms.
5. Counsel patients to return gradually to non-sports activities after no more than 2-3 days of rest.”

The CDC has also developed an educational program called “heads up: concussion in youth sports.”[19]

The American Academy of Neurology (AAN) has a position statement on sports concussion (2020) called concussion policy for youth and high school sports.[20] the AAN supports

educational resources such as the CDC'S heads up: concussion in youth sports online training course for coaches and parents and processes to confirm that the education is understood by parents and athletes. The AAN supports removal from participation for any athlete who is exhibiting symptoms or signs of a concussion until they are evaluated by a qualified healthcare provider properly trained in the assessment and management of concussion, such as a neurologist and as defined by state law. AAN recommends that student athletes should not return to athletic competition until the signs and symptoms of concussion have resolved and have been cleared by a qualified healthcare professional trained in the management of concussion, such as a neurologist. Student athletes should return to full academic participation before returning to competition.

[17] American College of Sports Medicine, American Academy of Famly Physicians, American Academy of Orthopaedic Surgeons, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, And American Osteopathic Academy Of Sports Medicine. "Concussion (Mild Traumatic Brain Injury) and the Team Physician: A Consensus Statement." 2013. Available at: https://cdn.ymaws.com/www.aoasm.org/resource/resmgr/PositionPapers/ConcussionandtheTeamPhysicia.pdf~~http://www.aoasm.org/default/assets/File/ConcussionandtheTeamPhysician.pdf.~~

[18] Centers for Disease Control and Prevention Guideline on the Diagnosis and Management of Mild Traumatic Brain Injury Among Children Jama Pediatr. 2018 November 01; 172(11): e182853. doi:10.1001/jamapediatrics.2018.2853

[19] no author. "heads up to youth sports." *centers for disease control and prevention*, no date. available at

https://www.cdc.gov/headsup/youthsports/index.html.

[20] AAN position: sports concussion 2020. available at

https://www.aan.com/policy-and-guidelines/policy/position-statements/sports-concussion.

The American Medical Society for Sports Medicine (AMSSM) recently published an update to their 2013 position statement on concussion in sport in 2019.[21] AMSSM recommends that any athlete suspected of having a concussion be removed from the activity and assessed by a licensed healthcare provider trained in the evaluation and management of concussions "reasons for immediate removal and prompt evaluation include loss of consciousness (LOC), impact seizure, tonic posturing, gross motor instability, confusion, or amnesia. Any of these reported or observed signs should result in removal from practice or competition for at least the rest of the day." Since concussions can cause changes in attention, learning, and short-term memory that make learning difficult, return to learn should be coordinated with school personnel to quickly implement a school support plan without delay. AMSSM recommends that "concussion-related symptoms and signs should be resolved before returning to sport. A return-to-play progression involves a gradual, stepwise increase in physical demands and sport-specific activities without return of symptoms before the final introduction of exposure to contact."

The American Academy of Pediatrics (AAP) updated their clinical report on sport-related concussion in children and adolescents in 2018.[22] AAP recommends that "testing after a sport-related concussion should be performed and conducted by providers who have been trained in the proper administration and interpretation of the tests." All athletes with a suspected concussion should be immediately removed from play. They should not return to full sports participation until they have completed a return-to-sport progression without a return of

concussion symptoms. Health care providers should be aware of their state's laws regarding return to play after a concussion.

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[21] HARMON KG, CLUGSTON JR, DEC K, ET AL. AMERICAN MEDICAL SOCIETY FOR SPORTS MEDICINE POSITION STATEMENT ON CONCUSSION IN SPORT. BRITISH JOURNAL OF SPORTS MEDICINE. 2019; 53:213-225. AVAILABLE AT HTTPS://BJSM.BMJ.COM/CONTENT/53/4/213.

[22] HALSTEAD ME, WALTER KD, MOFFATT K. SPORT-RELATED CONCUSSION IN CHILDREN AND ADOLESCENTS. PEDIATRICS. 2018; 142(6):e20183074.

As the above position statements demonstrate, there is a need for a stronger, unified voice from the medical community in order to provide state legislatures with the best tools and up-to-date guidance as they work to combat this public health concern. The AOA believes that emphasizing the physician-led, team-based model of care, where licensed health care providers at all levels possess current education and training in concussion management, will ensure that medical professionals with comprehensive knowledge of scientific evidence and advancements are appropriately involved in patient care.

AOA Policy Development

Strong evidence of the serious, negative long-term health effects of concussions underscores the need to create policy in this AREA to help guide osteopathic advocacy in response to current and proposed state legislation. Unified, evidence-based advocacy from medical groups, including the AOA, will benefit states as they update their concussion and RTP laws, which currently vary widely. The AOA adopts the following policy statements as its official position on concussion, RTP and RTL and encourages states, as well as schools, sports clubs and professional leagues to develop official rules that promote education and prevention of TBIS by incorporating these tenets:

1. **Parent and Student Education.** The AOA believes that educating students, parents and guardians about the nature, symptoms, risks and short- and long-term health effects of concussions and traumatic brain injuries will improve student safety by increasing awareness of concussion warning signs and allowing for early treatment. This has been shown to decrease the risk of subsequent injuries during recovery and improve long-term outcomes. Education should also include clarification of the RTP and RTL processes. The AOA believes that all schools and youth athletic organizations should disseminate evidence-based teaching tools such as those issued by the Centers for Disease Control (CDC), Sports Safety International (SSI), certain state members of the Brain Injury Alliance (BIA) or other nationally recognized health or medical organizations to students, parents and guardians prior to the start of every school year or athletic season.[23]

2. **Parent and Student Signature.** The AOA supports requiring signatures from parents/ guardians and students on an information sheet acknowledging that they have received the aforementioned education and been made aware of the risks of concussion inherent in athletic activities, and understand appropriate steps for concussion evaluation and management, prior to every school year or athletic season.

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[23] NO AUTHOR. “HEADS UP TO YOUTH SPORTS: PARENTS.” CENTERS FOR DISEASE CONTROL AND PREVENTION, NO DATE. AVAILABLE AT HTTPS://WWW.CDC.GOV/HEADSUP/YOUTHSPORTS/PARENTS.HTML.

3. **Coach/Official Training.** The AOA encourages states to adopt mandatory annual training for coaches, athletic directors, school nurses and other school and youth sports officials based upon materials published by the CDC, SSI, BIA or other nationally recognized health or medical organizations.[24] Training should emphasize prevention as well as the need for early identification of concussions and improve treatment and management strategies, with an emphasis on prohibiting same-day return-to-play for concussed athletes in all circumstances and requiring clearance from a physician (as defined elsewhere in AOA policy) prior to allowing a concussed athlete to return to athletic activity.

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[24] NO AUTHOR. “HEADS UP TO SCHOOLS: TEACHERS, COUNSELORS, AND SCHOOL PROFESSIONALS.” CENTERS FOR DISEASE CONTROL AND PREVENTION, NO DATE. AVAILABLE AT HTTPS://WWW.CDC.GOV/HEADSUP/SCHOOLS/TEACHERS.HTML.

4. **Removal and Return-to-Play.** The AOA believes that it is vital that youth suspected of having sustained a concussion be removed from practice or competition immediately, and examined by a member of the physician-led team who is a licensed health care provider (LHCP) with documentation reflecting current concussion training, whose scope of practice includes the evaluation and management of concussions. The AOA supports the use of baseline testing conducted by a trained health care professional prior to the start of each athletic season or school year to assess a youth's balance and cognitive function as well as the presence of any concussion symptoms.[25] At the time of a suspected concussion, results from this baseline testing can be compared to results from post-concussive testing again assessing balance and cognition. If the provider suspects a possible concussion, the athlete should be evaluated by a physician immediately. There should be no same-day return-to-play for athletes diagnosed with a concussion, and no subsequent return-to-play without written clearance by a physician with documented current concussion training. For students diagnosed with a concussion, examining physicians should work with parents/guardians, coaches, athletic trainers and other stakeholders on ongoing concussion management and gradual RTP and RTL for the student athlete. The examining physician should also coordinate with a multi-disciplinary team that may include physical therapists, occupational therapists, neuropsychologists, cognitive rehabilitation specialists and certified athletic trainers, among others, as the patient recovers from suffering from a concussion.

5. **Clearing Provider Type.** The AOA believes a LHCP member of the physician-led team who is trained in the evaluation and management of concussions, such as a certified athletic trainer or school nurse, may conduct a sideline assessment. If a youth's sideline assessment indicates a possible concussion, the youth must be evaluated by an allopathic or osteopathic physician with expertise in concussion management, who shall establish a clinical diagnosis. Proof of this expertise may include concussion training in sports medicine fellowship, or documentation of course completion in a recognized concussion course such as one from the CDC or SSI. Physicians possess the most comprehensive education and training of any health care provider, which enables them to recognize the variable and often subtle signs of concussion. The evaluating physician shall create a treatment plan and work with other members of the physician-led team to implement it, and the youth may only return to athletic activity with written clearance from the evaluating physician.

6. **Return-to-Learn.** The AOA recommends that the evaluating physician work with school officials to implement an RTL protocol for students following a concussion. The physician may adjust the protocol with school officials as the patient's symptoms evolve and gradually improve, usually within one to three weeks after the injury. Each concussion is an individualized entity, however, and as such should be treated by the physician on an individualized basis with the physician making the deciding determination regarding RTL. The physician should communicate the importance of cognitive rest following a concussion to parents and school officials, emphasizing that a student may require a lighter workload, exemption from classes that appear to exacerbate concussion symptoms, and/or testing extensions until symptoms improve or disappear.

[25] NO AUTHOR. “FAQS ABOUT BASELINE TESTING.” CENTERS FOR DISEASE CONTROL AND PREVENTION, NO DATE. AVAILABLE AT HTTPS://WWW.CDC.GOV/HEADSUP/BASICS/BASELINE_TESTING.HTML.

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Osteopathic Medicine -- Autonomy of

Policy Statement

Policy of the American Osteopathic Association states that the osteopathic profession, in the interest of providing the best possible healthcare to the public, shall maintain its status as a complete and distinct philosophy of medicine.

Source: H414-A/21

Status: 1959; 1965 Reaffirmed, 1974 Reaffirmed; 1980 Reaffirmed, 1985 Reaffirmed; 1990 Reaffirmed as Amended, 1996 Reaffirmed, 2001 Reaffirmed; 2006 Reaffirmed; 2011 Reaffirmed; 2016 Reaffirmed; 2021 Reaffirmed

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Chelation Therapy

Policy Statement

The American Osteopathic Association does not endorse chelation therapy as useful treatment for other than its current Food and Drug Administration approved use, and as medical evidence supports.

Source: H415-A/21

Status: 1985; 1990 Reaffirmed as Amended; 1995 Reaffirmed; 2000 Reaffirmed as Amended; 2005 Referred; 2006 Reaffirmed as Amended; 2011 Reaffirmed; 2016 Reaffirmed as Amended; 2021 Reaffirmed as Amended

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Minority Health and Osteopathic Medical Education

Policy Statement

The American Osteopathic Association encourages the development of internal programs to address the disproportionate incidence of preventable diseases in minority populations, the impaired access to quality healthcare in minority communities, and the under representation of minority populations in osteopathic medicine; and will work with the American Association of Colleges of Osteopathic Medicine (AACOM), and towards eliminating such disparities within its osteopathic medical educational processes, and collaborate with federal/state governments, academia, and the healthcare industry to develop programs to eliminate medical and academic disparities between minority and non-minority groups in the US.

Source: H416-A/21

Status: 1996; 2001 Reaffirmed; 2006 Reaffirmed as Amended; 2011 Reaffirmed; 2016 Reaffirmed; 2021 Reaffirmed as Amended

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Obesity in Children

Policy Statement

The American Osteopathic Association supports programs which advocate physical fitness and good nutrition for children and families.

Source: H417-A/21

Status: 2001; 2006 Reaffirmed as Amended; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed

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Sports, Fitness and Nutrition

Policy Statement

The American Osteopathic Association supports the President's Council on Sports, Fitness and Nutrition.

Source: H418-A/21

Status: 1991; 1996 Reaffirmed as Amended; 2001 Reaffirmed; 2006 Reaffirmed;
2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed as Amended

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Plastic Beverage and Food Container Recycling Act

Policy Statement

The American Osteopathic Association supports conservational recycling and encourages that materials are made from recycled products.

Source: H419-A/21

Status: 1990, 1995 Reaffirmed as Amended; 2000 Reaffirmed; 2006 Reaffirmed; 2011 Reaffirmed as Amended 2011; 2016 Reaffirmed; 2021 Reaffirmed

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Childhood and Teenage Sexual Exposure

Policy Statement

The American Osteopathic Association: (1) encourages osteopathic physicians to provide anticipatory guidance to minor children about the risks of sexual exposure and sexually-transmitted diseases, and provide this same guidance to their parents and/or caregivers; (2) encourages osteopathic physicians to support the development of curriculum by local, state and national educational organizations that will lead to the prevention of unwanted pregnancy and transmission of disease, using medically appropriate measures, preferably abstinence and avoidance of high risk sexual behavior; and (3) support public education efforts to prevent unwanted pregnancy and sexually transmitted infections.

Source: H420-A/21

Status: 2005; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed as Amended

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Tobacco Control – The Framework Convention on

Policy Statement

The American Osteopathic Association support the efforts of international health agencies in eliminating the use of tobacco products, smokeless tobacco products, and vaporizing products from their societies, and encourage the United States to use its experience in tobacco products control, smokeless tobacco products control, and vaporizing products control to help developing countries with this health issue and support the public health initiatives of the World Health Organization for tobacco products control, smokeless tobacco products control, and vaporizing products control by promoting the Framework Convention on Tobacco Control (FCTC) and urge the President of the United States to submit the framework convention on tobacco products control, smokeless tobacco products control, and vaporizing products control to the United States Senate for ratification.

Source: H421-A/21

Status: 2001; 2006 Reaffirmed as Amended; 2011 Reaffirmed as Amended;
2016 Reaffirmed Amended; 2021 Reaffirmed

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Damage to Hearing from use of Headphones

Policy Statement

The American Osteopathic Association (1) supports public education campaigns to increase awareness among children and their parents of the potential risk of noise-induced hearing loss that can occur from listening to headphones at high volumes for extended periods of time; (2) encourages manufacturers to include information about the hazards of unsafe volume levels on or within product packaging and to recommend implementation of built-in mechanisms that can be enabled to limit a product's decibel output; and (3) encourages osteopathic physicians to actively educate young people and parents about the safety concerns of using headphones and the necessary safeguards to prevent hearing damage.

Source: H422-A/21

Status: 2011; 2016 Reaffirmed; 2021 Reaffirmed as Amended

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Dangers of the “Choking Game”

Policy Statement

The American Osteopathic Association supports increasing awareness among parents, educators, counselors and physicians of the risks and warning signs associated with the choking game and of the resources available for educating teens about the dangers of the choking game; and supports the inclusion of information about the dangers of the “choking game” in classroom education and other school-sponsored discussions about drugs and risky behaviors.

Source: H423-A/21

Status: 2011; 2016 Reaffirmed; 2021 Reaffirmed

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Medical Cannabis – Research on

Policy Statement

The American Osteopathic Association supports well-controlled clinical studies on the use of cannabis, commonly referred to as marijuana, and related cannabinoids for patients who have significant medical conditions for which current evidence suggests possible efficacy; and encourages the National Institutes of Health (NIH) to facilitate the development of well-designed clinical research studies into the medical use of cannabis.

Source: H424-A/21

Status: 2011; 2016 Reaffirmed as Amended; 2021 Reaffirmed

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Blood Donors, Protection from Depletion of Iron

Policy Statement

The American Osteopathic Association encourages blood collection facilities to establish guidelines to identify frequent blood donors, and institute the necessary testing to monitor their iron stores.

Source: H426-A/21

Status: 2006; 2011 Reaffirmed; 2016 Reaffirmed; 2021 Reaffirmed

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5-2-1-0+10 Campaign for America's Children

Policy Statement

The American Osteopathic Association recommends the continued support of the 5-2-1-0+10 campaign for America's children. 5-2-1-0+10 stands for 5 servings of fruits and vegetables each day, 2 hours or less of recreational screen time per day, 1 hour of physical activity per day, 0 sweetened or sugary drinks, and 10 hours of sleep every night for children.

Source: H427-A/21

Status: 2011; 2016 Reaffirmed as Amended; 2021 Reaffirmed as Amended

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Obesity Epidemic – Addressing the American

Policy Statement

The American Osteopathic Association, in conjunction with its specialty and divisional affiliates, the American Association of Colleges of Osteopathic Medicine, the National Board of Osteopathic Medical Examiners and the certifying boards, will initiate a profession-wide program to provide leadership in addressing the American obesity epidemic~~;~~ encourages each osteopathic physician and medical student to measure the body mass index (BMI) and waist circumference in every patient and address with them their obesity-related issues, and also encourages each osteopathic physician and student to address any obesity-related issues in their own health as an example to their patients.

Source: H429-A/21

Status: 2011; 2016 Reaffirmed; 2021 Reaffirmed

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Mandatory Influenza Vaccine of Healthcare Personnel

Policy Statement

The American Osteopathic Association recommends mandatory seasonal Influenza vaccination of all healthcare personnel and that medical exemptions to required influenza immunization (e.g., life threatening allergic reaction after receiving an influenza vaccine or severe allergy to a vaccine component) should be kept at a minimum to ensure high coverage rates and granted only on an individual basis.

Source: H430-A/21

Status: 2016; 2021 Reaffirmed

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Title X Funded Family Planning Services – Support for

Policy Statement

The American Osteopathic Association believes that Title X funded family planning services are critical components of public health and primary health care and shall advocate for Title X funded family planning services.

Source: H431-A/21

Status: 2016; 2021 Reaffirm

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Shackling of Pregnant Inmates

Policy Statement

The American Osteopathic Association acknowledges the potential harm shackling can cause harm to both the mother and fetus, including miscarriage, and premature birth; and supports restricting the use of any form of shackling on an inmate who is pregnant or in labor unless the woman is an immediate and serious threat to herself or others or if the woman is a substantial flight risk.

Source: H432-A/21

Status: 2016; 2021 Reaffirmed

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Lesbian, Gay, Bisexual, Transgender, Queer / Questioning, Intersex, Asexual Protection Laws

Policy Statement

The American Osteopathic Association (AOA) supports the protection of Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual (LGBTQIA+) individuals from discriminating practices and harassment and reaffirms equal rights and protections for all patient populations as stated in the AOA Rules and Guidelines on Professional Conduct.

Source: H434-A/21

Status: 2016; 2021 Reaffirmed as Amended

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Osteopathic Manipulative Medicine (OMM) and Osteopathic Manipulative Treatment (OMT) – Affirming the Scientific and Medical Foundation of

Policy Statement

The American Osteopathic Association continues to affirm its position that the scientific and medical foundation of osteopathic manipulative medicine (OMM) and osteopathic manipulative treatment (OMT) is integral to this distinctive practice; and advocates for proper recognition of the scientific and medical foundation of osteopathic manipulative medicine (OMM) and osteopathic manipulative treatment (OMT) to all political bodies, research groups, third party payers, and any other entity that formulates policy on OMM and OMT.

Source: H436-A/21

Status: 2011; 2016 Reaffirmed; 2021 Reaffrimed

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Third Party Payors Changing Classes of Medications

Policy Statement

The American Osteopathic Association supports all efforts to end the practice of requiring a change in class of medication, thereby decreasing the administrative burden and improving access to care.

Source: H437-A/21

Status: 2006; 2011 Reaffirmed; 2016 Reaffirmed; 2021 Reaffirmed

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Physician Comparative Utilization and Profiling

Policy Statement

The American Osteopathic Association (AOA) adopts the following principles on physician comparative utilization and physician profiling.

The physician comparative utilization, rating, and profiling programs should exclusively use metrics that are developed with physician involvement. Where possible, measure sets and/or data points should be evidenced-based and vetted by relevant physician specialty or professional societies. The measure constructs should be evaluated on a timely basis to reflect validity, reliability and impact on patient care. Additionally, all evidenced-based measures should be reviewed in light of evolving evidence to maintain the clinical relevance of all measures.

Comparative utilization, profiling, and rating should only occur once data has been acquired from a statistically significant sample of a physician's patient population which has been risk adjusted.

Comparisons between physicians should be based on geographic/demographic (rural, urban, suburban) comparisons of similar practice specialty.

Anonymous patient satisfaction data, whether in a formal profiling program or through an informal consumer website, should be excluded.

Physicians should have the opportunity to review any data or rating for accuracy and be afforded the right to request changes to inaccurate information in advance of the publication of that data. All methodologies, including those used to determine case identification and measure definitions, should be transparent and readily available to physicians.

If comparative utilization or physician profiling data were to be made public, only measures that are deemed sensitive and specific to the care being delivered are used and appropriate context and methodology are shared with the public.

The physician rating and profiling program(s) should not adversely impact the physician-patient relationship or unduly intrude upon physicians' medical judgment.

Source: H438-A/21

Status: 2016; 2021 Reaffirmed as Amended

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Physician Supply in Rural, Underserved United States – Recommendations for Improving

Policy Statement

The American Osteopathic Association will work toward improving rural physician supply and monitor the potential for nationwide implementation of the following recommendations:

Recommendations for Improving Physician Supply in Rural Underserved America

1. Support Practice Incentive / Benefit and Other Recruitment Programs
   - Federal and state rural practice incentive/benefit programs should be sufficiently funded to be successful in recruiting and retaining physicians in rural, underserved communities.
   - Physicians, medical students and residents should have easy access to information about rural practice incentive programs. Further, the programs should be widely publicized by state authorities, and application forms readily accessible and user-friendly.
   - Area Health Education Centers need to be adequately funded through federal and state funding sources to: a) provide recruitment and retention services in rural areas; b) assist in locating reasonable housing for student and resident preceptorships; and c) provide practice support services to providers and communities, as referenced in other principles listed herein.
   - Incentives should be developed by state authorities to encourage physicians to add a secondary, part-time practice in rural, underserved communities located within a reasonable distance of their primary practice site. Physicians are encouraged to consider hiring and supervising mid-level practitioners, as appropriate, to augment their secondary practices.
   - Physicians are urged to adopt telemedicine services in their practices as outreach to patients in underserved communities, within the scope of their licensure and receive appropriate payment, when applicable and purposeful in meeting health care needs.
   - Physicians should be informed of the potential impact of the employed-practice model on their scope of practice before signing hospital employment contracts, including resources provided.
2. Support Promotion of Rural Practice
   - Information on rural physician shortage areas should be readily available through coordinated websites of state agencies, area health education centers, practicing physicians, medical students, and residents seeking rural practice opportunities, as well as to underserved communities. To assist physicians in selecting practice opportunities, comprehensive community profiles should be compiled to identify characteristics and statistics such as: population demographics {percentage child-bearing (for obstetrical needs), aged (for adult medicine-needs), etc.}, insurance status, supply of physicians and other health professionals, degree of physician shortage, socioeconomic status, as well as educational and recreational opportunities.
   - Physicians who locate to rural areas, as well as medical students and residents interested in locating to rural areas, should be informed by state and/or local authorities of benefits and incentives available to strengthen the financial viability of their practice, including Medicare bonus payments, recruitment assistance, publicly funded locum tenens programs, tax credits, loan repayment opportunities, etc. Further, they should be

informed of the health care infrastructure in their area, including systems of care such as federally qualified health centers, indigent care clinics, rural health clinics, hospitals (including Critical Access Hospitals), long term care facilities, emergency medical services, and hospice. They should also be informed about the availability of other health providers and services such as nursing, pharmacies, therapists, medical equipment, etc.

- County medical societies, hospitals, and other health facilities (when available) should facilitate communication between new physicians and physicians with established practices in the community to help new physicians be better prepared for entering practice in an underserved community.
- Physicians who receive benefits through state loan repayment programs should also be informed by state authorities of specialized practice support services, including practice start-up, billing, locum tenens, professional development and CME, staff recruitment and training, telemedicine, etc.
- Physician practice re-entry programs should be widely publicized and monitored to assess their ability to meet demands by state authorities. Further, when physicians allow their medical license to lapse, they should be informed by the relevant state licensing authority of the potential obstacles to re-licensure should they decide to re-enter practice following an extended absence from practice.
- Outreach should be provided by state authorities, to physicians without a full-time medical practice to promote volunteer work or part-time practice at clinics in underserved communities.
- Federal and state policies that impact rural medicine, e.g., payment policies, should be monitored for their potential impact on the viability of rural practices. The American Osteopathic Association should continue to advocate for payment parity between Medicaid and Medicare.
- Physicians in practice and those in training programs should be informed by state authorities, of special state medical licensing provisions applicable for practice in rural, underserved areas.

3. Support for Preparing Physicians for Rural Practice
    - Medical schools and residency programs should be incentivized by state authorities to develop and adequately support rural education and training tracks.
      Examples:
        a. Bonuses for medical students or residents who participate in rural training tracks; and
        b. Additional state formula funding for medical student and residents in rural training tracks.
    - Appropriate criteria should be used by Post-Doctoral training programs for identifying student-applicants and residents most likely to be successful in rural practice.
    - To measure outcomes, assessments should be conducted to identify whether students and residents who participate in rural educational or training tracks are retained in the state for practice after completion of training.
    - Area health education centers should offer opportunities for community physicians who volunteer as preceptors to access information and knowledge of practices that contribute to a positive clinical learning experience. Further, educational institutions should provide adequate support and incentives to recruit and retain physician preceptors, including appropriate levels of recognition and benefits for their teaching efforts. This will become increasingly important as community physicians face continuing pressures to increase productivity.

- Medicare GME policies should allow for residency program-specific support rather than institutional support for resident training to allow GME funding to follow the resident throughout their training.
- The Accreditation Council for Graduate Medical Education should consider allowing more flexibility for residents to travel away from their core programs to rural areas in order to achieve established training goals for minimum numbers of procedures or encounters.
- The impact of changes in resident duty-hour restrictions should be monitored for the impact on rural training programs and health care delivery in comparison to institution-based residency programs.

4. Support for Rural Access to Care
    - Develop solutions for providing after-hours care for patients of federally-funded health clinics requiring urgent or emergent care to prevent undue burdens on community physicians.

Source: H439-A/21

Status: 2011; 2016 Reaffirmed as Amended; 2021 Reaffirmed as Amended

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Alternative Payment Models – Ensuring Do Opportunities and Patient Access In

Policy Statement

The American Osteopathic Association (AOA) will advance federal and state polices to ensure alternative payment models (APM) that: (1) offer high quality healthcare to all patients; (2) empower physicians to engage patients in making decisions involving their healthcare, including both economic and clinical decisions; (3) permit freedom of choice of hospital and doctors within the scope of the care model; (4) allow participation of osteopathic physicians including as part of the leadership, board, or other administrative body of the APM; permit the patient to make economic decisions involving his healthcare; (5) will not exclude DOs on the basis of degree or AOA certification or training; (6) will provide providers with information about the costs, risk, and payments associated with practicing in the APM; (7) apprise participating physicians of the progress of the APM; (8) do not exclude physicians and hospitals who are not part of the APM from honest competition for any segment of the marketplace; (9) afford all physicians appropriate hearing and appeal processes.

Source: H440-A/21

Status: 1988; 1993 Reaffirmed as Amended, 1994 Reaffirmed, 1999 Reaffirmed; 2004 Referred; 2006 Reaffirmed; 2016 Reaffirmed as Amended;2021 Reaffirmed

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Health Insurance Coverage for Medical and Surgical Treatments for Good Oral Health

Policy Statement

The American Osteopathic Association supports the concept that medical insurance coverage should include medical and surgical treatments as needed to support good oral health, especially for patients with comorbid conditions.

Source: H441-A/21

Status: 2001; 2006 Reaffirmed; 2011 Reaffirmed; 2016 Reaffirmed as Amended; 2021 Reaffirmed

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Physician Profiles

Policy Statement

It is the American Osteopathic Association's position that state medical or osteopathic boards, as the licensing and regulatory authorities for physicians, are the appropriate entities to collect, maintain, and disseminate physician profile information to the public; supports the position that any legislation or regulations which mandate the release of physician profile information provide funding for the creation and maintenance of the profiling system without added expense to the physician; supports the position that only physician profiles that incorporate all of the following five principles (fairness, relevancy, timeliness, accuracy, and reliability) should be released to the public; opposes the inclusion of medical malpractice histories within physician profiles due to their susceptibility to misinterpretation and inherently prejudicial effect; supports the position that before physician profiles are released to the public, every physician has the opportunity to verify the accuracy of the information and to contest any incorrect information before it is disseminated to the public; and believes that the state licensing boards must include an appeal mechanism in their regulations that a physician may pursue if any information in his or her profile is inaccurate, and institute appropriate corrections.

Source: H442-A/21

Status: 2001; 2006 Reaffirmed; 2016 Reaffirmed; 2021 Reaffirmed

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AOA Support of Public Health Service

Policy Statement

The American Osteopathic Association recognizes the contribution of the US Public Health Service (PHS) Commissioned Corps to the healthcare of the United States and supports the continued existence of the United States Public Health Service Commissioned Corps.

Source: H401 – A/22

Status: 1981; 1986 Reaffirmed as Amended; 1991 Reaffirmed, 1992 Reaffirmed, 1997 Reaffirmed, 2002 Reaffirmed; 2007 Reaffirmed, 2012 Reaffirmed; 2017 Reaffirmed; 2022 Reaffirmed

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Genetic Testing

Policy Statement

The American Osteopathic Association supports the public interest in prohibiting discrimination in employment, insurance coverage, and access to care on the basis of genetic information.

Source: H403 – A/22

Status: 1997; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed; 2022 Reaffirmed

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Substance Impaired and Distracted Driving

Policy Statement

The American Osteopathic Association pledges its support to law enforcement agencies in their efforts to enforce substance impaired and distracted driving statutes; encourages agencies in government and in the private sector to promote greater public awareness of the problem; and encourages its members, through discussions with their patients and their communities, to actively assist in the effort by making the problem and its prevention more visible to the public.

Source: H404 – A/22

Status: 1997; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed; 2022 Reaffirmed

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Accessibility to Breast Cancer Prevention, Detection, Diagnosis and Treatment

Policy Statement

The American Osteopathic Association supports development and application of the latest advances in breast cancer prevention, detection, diagnosis, and treatment, with dissemination as rapidly as possible to the medical community and the public it serves; and urges adoption of measures and programs to improve access to breast cancer screening for all appropriate patient populations.

Source: H405 – A/22

Status: 2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed; 2022 Reaffirmed

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Support For Prenatal and Pediatric Hospice and Palliative Care

Policy Statement

The American Osteopathic Association endorses the practice of hospice and palliative medicine in prenatal and pediatric patient populations; urges that osteopathic physicians providing prenatal care or consultation be knowledgeable about the existence and availability of prenatal hospice and palliative care, and offer it as an option to parents of a baby with a likely fatal fetal anomaly; and supports organizations dedicated to the promotion, education and provision of prenatal and pediatric hospice and palliative care.

Source: H406 – A/22

Status: 2007; 2012 Reaffirmed; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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Prevention and Treatment of Obesity

Policy Statement

The American Osteopathic Association recognizes obesity as a disease which requires a chronic care model to address prevention and treatment. The AOA encourages research at colleges of osteopathic medicine; endorses continued curriculum enhancement for osteopathic students, interns, and residents to receive specific training in obesity education and supports continuing medical education for physicians with established practices. The AOA supports efforts to close the gap between current and desirable practice patterns, by soliciting grants to collect and study the extent to which obesity treatment and prevention services are covered by third party insurers and will advocate for adequate coverage for obesity treatment and prevention. The AOA supports comprehensive efforts, commensurate with available funding, to disseminate knowledge to the treating community, media, legislature and employer groups directed at controlling the obesity epidemic by improving treatment access and encouraging physical activity.

Source: H408 – A/22

Status: 2002; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed; 2022 Reaffirmed as Amended

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Contraceptive Coverage Legislation

Policy Statement

The American Osteopathic Association supports health insurance coverage for federal Food and Drug Administration (FDA) approved contraceptive services and supports language which would maintain co-payment for contraceptive services at a cost no higher than the set level of co-payment for any other prescription.

Source: H409 – A/22

Status: 1999; 2004 Reaffirmed as Amended; 2009 Reaffirmed; 2017 Reaffirmed; 2022 Reaffirmed as Amended

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Promotion for the Requirement of All Sporting Events to Have Access to an Automated External Defibrillator (AED)

Policy Statement

The American Osteopathic Association requests: the Food and Drug Administration (FDA) to be diligent in their monitoring of all products marketed for human consumption, including nutritional supplements, and that there be close attention to reported adverse events directly caused by any of these products; and that the US Congress pass legislation requiring dietary supplements to undergo pre-market safety and efficacy evaluation by the FDA.

Source: H410-A/22

Status: 2012; 2017 Reaffirmed; 2022 Reaffirmed as Amended

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Meningococcal Vaccine Recommendations

Policy Statement

The American Osteopathic Association supports the administration of meningococcal vaccines as recommended by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP); and urges adequate public and private insurance coverage for vaccines in patient populations as recommended by the ACIP

Source: H411-A/22

Status: 2012; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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PSA-Based Screening for Prostate Cancer

Policy Statement

The American Osteopathic Association recognizes and promotes the importance of the integrity of the patient-physician relationship and recommends that prostate cancer clinical preventive screenings be individualized.

Source: H412-A/22

Status: 2012; 2017 Reaffirmed; 2022 Adopted

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Mandates on School Lunches

Policy Statement

The American Osteopathic Association advocates for a holistic approach with respect to childhood nutrition and wellness without mandates that force children to purchase school lunches.

Source: H413-A/22

Status: 2012; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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Antimicrobial Stewardship

Policy Statement

The American Osteopathic Association supports antimicrobial stewardship education in order to decrease drug-resistant organisms.

Source: H414-A/22

Status: 2002; 2007 Reaffirmed as Amended; 2012 Reaffirmed; 2017 Reaffirmed; 2022 Reaffirmed as Amended

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Anti-Bullying Policy

Policy Statement

The American Osteopathic Association supports anti-bullying policies enabling students to go to school in a peaceful manner without fear of being tormented or intimidated and supports a policy to prevent bullying in schools and provide treatment for those involved.

The AOA acknowledges that successful antibullying interventions recognize the nature of bullying behavior as complex and related to mental health and societal influences, and that all those involved can suffer detrimental physical and mental health effects.

Source: H415-A/22

Status: 2002; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed as Amended; 2022 Reaffirmed as Amended

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Promotion, Protection and Support of Breastfeeding

Policy Statement

The American Osteopathic Association encourages its membership to take a role to protect, promote and support breastfeeding and encourages the provision of breastfeeding friendly environments in their places of study and work, including but not limited to colleges, hospitals, and other healthcare facilities.

Source: H416-A/22

Status: 2002; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed as Amended; 2022 Reaffirmed as Amended

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Promoting Emergency Medical Identification Programs

Policy Statement

The American Osteopathic Association supports the concept of medical identification systems, and urges that osteopathic physicians encourage their patients to participate in an emergency medical identification program.

Source: H417-A/22

Status: 1981; 1985 Reaffirmed; 1991 Reaffirmed as Amended, 1992 Reaffirmed; 1997 Reaffirmed; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed; 2022 Reaffirmed as Amended

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Organ Donation – Opposition to Incentives for Organ Donors

Policy Statement

The American Osteopathic Association opposes direct payment or other financial inducement in exchange for donation of human organs and tissue and urges the investigation of other, more ethical alternatives to raising organ donor identification rates while protecting patient.

Source: H418-A/22

Status: 2002; 2007 Reaffirmed, 2012 Reaffirmed; 2017 Reaffirmed as Amended; 2022 Reaffirmed as Amended

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Violence in the Entertainment Media

Policy Statement

The American Osteopathic Association opposes the presentation of gratuitous violence in the entertainment media.

Source: H419-A/22

Status: 1977; 1982 Reaffirmed as Amended; 1987 Reaffirmed; 1992 Reaffirmed; 1997 Reaffirmed; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed; 2022 Reaffirmed

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Stem Cell Research

Policy Statement

Insert Policy: The American Osteopathic Association supports biomedical research on stem cells and will continue to monitor developments in stem cell research and sources of stem cell funding.

Source: H420-A/22

Status: 2007; 2012 Reaffirmed; 2017 Reaffirmed; 2022 Reaffirmed

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Education on Human Papillomavirus Vaccination

Policy Statement

The American Osteopathic Association supports efforts to educate the general public regarding the Human Papilloma Virus (HPV) and its relationship to certain cancers and genital warts; urges osteopathic physicians to educate themselves and their patients regarding the availability and benefits of administering HPV vaccine to patients as recommended by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP); and urges adequate public and private insurance coverage for HPV vaccines in patient populations as recommended by the Advisory Committee on Immunization Practices (ACIP); and supports ongoing research to determine whether HPV vaccine is beneficial to other groups in the general population.

Source: H421-A/22

Status: 2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed; 2022 Reaffirmed

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Daily Physical Education for Grades K-12

Policy Statement

The American Osteopathic Association supports daily physical education for all US students in grades K-12.

Source: H422-A/22

Status: 1981; 1986 Reaffirmed; 1991 Reaffirmed as Amended, 1992; 1997 Reaffirmed, 2002 Reaffirmed as Amended; 2007 Reaffirmed as Amended; 2012 Reaffirmed as Amended; 2017 Reaffirmed; 2022 Reaffirmed

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Use of Tobacco Products

Policy Statement

The American Osteopathic Association supports education on the hazards of tobacco products beginning at the elementary school level; encourages physicians to inquire into tobacco use and exposure as part of both prenatal visits and every appropriate health encounter; strongly recommends that all federal and state health agencies continue to take positive action to discourage the American public from using cigarettes and other tobacco products; encourages its members to discuss the hazards of tobacco use with their patients; encourages the elimination of federal subsidies and encourages increased taxation of tobacco products at both federal and state levels suggesting that monies from the additional taxation could be earmarked for smoking-reduction programs and research for prevention of tobacco-related diseases; and that municipal, state and federal executive agencies and lawmakers enact clean-indoor air acts, a total ban on tobacco product advertising, opposes cigarette vending machines in general and supports the elimination of free distribution of cigarettes or tobacco products in the United States; and that grades K -12 should be encouraged to incorporate a curricular component that has been proven effective in preventing tobacco usage in its health education curriculum; urge the development of anti-tobacco educational programs targeted to all members of society, with the ultimate goal of achieving a tobacco-free nation.

Source: H423-A/22

Status: 1990; 1995 Reaffirmed as Amended; 1997 Reaffirmed; 2002 Reaffirmed as Amended; 2007 Reaffirmed; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended; 2022 Reaffirmed as Amended

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Powdered Caffeine

Policy Statement

The American Osteopathic Association opposes the use of concentrated powdered caffeine for non-medical uses.

Source: H425-A/22

Status: 2017; 2022 Reaffirmed

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Health Insurance Coverage for Residential Treatment and Inpatient Treatment of Eating Disorders

Policy Statement

The American Osteopathic Association supports improved access to treatment in residential and inpatient facilities and efforts to reduce the financial barriers of intensive treatment for patients suffering from eating disorders; encourages residential and inpatient treatment facilities caring for patients suffering from eating disorders, to manage care in consideration of the patient's overall medical and mental health needs, and to continue treatment until goals of weight restoration and physiologic status are obtained; and supports continued care for individuals suffering from eating disorders staying in residential and inpatient facilities, regardless of insurance criteria requiring termination of treatment.

Source: H426-A/22

Status: 2017; 2022 Reaffirmed

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Recreational Cannabis Use by Physicians, Students and Patients
White Paper

Policy Statement

H428-A2022 Recreational Cannabis Use by Physicians, Students, and Patients White Paper

Purpose

This policy paper addresses the potential risks and benefits of recreational cannabis, the potential risks and benefits of medical cannabis, and policy guidelines for the use of these substances by osteopathic medical students, physicians, and patients. The policy paper provides the following:

1. Summary of current literature regarding risks and benefits of cannabis as a foundation for policy development around cannabis for both medicinal and recreational use.

2. Discussion of the driving forces in the legalization/decriminalization of cannabis use at the state level.

3. Policy recommendations around risk/benefit of cannabis use and its potential impact on osteopathic physicians and students as well as patients.

Background

In 2020, 17.9% of people aged 12 and older used cannabis. The percentage of people who used cannabis in the past year was highest among young adults aged 18 to 25 (34.5%) compared with 16.3% of adults aged 26 or older and 10.1% of adolescents aged 12 to 17.[1] As of January 2022, 36 states, the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands have approved comprehensive, publicly available cannabis for medicinal and recreational use.[2]

The trend of legalizing cannabis illuminates two, often competing, forces which are: (1) a greater public acceptance of cannabis for medicinal and recreational use; and (2) a concern for the impact of existing laws governing cannabis possession and use on the societal as well as personal level. As states continue to legalize medicinal and recreational cannabis use, it is important to take into consideration the potential public health threat cannabis use represents. Similar to alcohol consumption and tobacco use, osteopathic physicians must guide the care of patients as cannabis use moves from a criminal act to an acceptable behavior, albeit a behavior that may pose a public health threat.[2]

Risks and Benefits of Cannabis

A systematic review of cannabis was commissioned by the National Academy of Science, Engineering and Medicine (the Academies) in April 2016 and published on January 17, 2017, the most up to date, comprehensive report.[3]

The commissioned report is the first comprehensive review of published literature since the 1999 Institute of Medicine (IOM) Report, Marijuana and Medicine: Assessing the Science Base. The Academies' report is entitled, The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research.[3] This publication represents the best current knowledge regarding the risks and benefits of cannabis synthesized by leading national researchers. In addition, the report describes gaps in the literature, identifies future research opportunities, and summarizes policy issues regarding the laws and uses of cannabis across the various states that have decriminalized cannabis. The report also discusses current federal activities such as the enforcement of the Controlled Substance Act.

The committee commissioned by the Academies conducted an extensive search of relevant databases which included Medline, Embase, the Cochrane Database of Systematic Reviews, and PsycINFO. The committee identified more than 24,000 abstracts of articles published since the 1999 IOM report. Only articles published in English were eligible for the study. Case reports, editorials, studies by "anonymous" authors, conference abstracts, and commentaries were excluded. Ultimately, the committee conducted an in-depth review of more than 10,700 abstracts in determining their relevance to the final report.

Summary of Major Findings[3]

Therapeutic Benefits. Research has demonstrated that cannabis use has therapeutic effects for patients. Oral cannabinoids are an effective antiemetic in treating nausea and vomiting resulting from chemotherapy treatment. With respect to chronic pain, cannabis and/or cannabinoids can significantly reduce pain symptoms for chronic pain (e.g., fibromyalgia) patients. For multiple sclerosis patients, short-term use of oral cannabinoids improves patient-reported spasticity symptoms. Other therapeutic benefits of cannabis may be seen in patients that suffer from Tourette syndrome, Posttraumatic Stress Disorders (PTSD) and social anxiety disorders. More research, however, is needed for the effects of cannabinoids on other conditions such as epilepsy, Parkinson's disease, and schizophrenia.[3]

Cancer Risks. Cannabis use poses health risks for various diseases and conditions as well as injury and death. There is modest evidence that cannabis use is associated with an increased incidence of a specific type of testicular cancer. There is insufficient evidence that cannabis use increases the risk of other cancers (e.g., esophageal, prostate, cervical, leukemia, or cancer in children whose mother used cannabis during her pregnancy), and there is no evidence that smoking cannabis increases the risk of such cancers as lung cancer or head and neck cancer.[3]

Pulmonary & Cardiometabolic Concerns. Cannabis use and its growing popularity raise questions regarding pulmonary and cardiometabolic issues. Evidence has shown that regular use of cannabis is associated with chronic cough and phlegm production. More research, however, is needed to determine whether smoking cannabis is associated with Chronic Obstructive Pulmonary Disease (COPD), asthma, and/or a decline in lung function. More research is also needed to determine the exact association of cannabis use with heart attack, stroke and diabetes.[3]

Effect on Infectious Diseases. There is a lack of evidence regarding the effects of cannabis on the human immune system. There has been some belief that cannabis use has adverse effects on the immune system of HIV patients. More research is needed to determine a statistical association. According to the limited evidence that does exist, smoking cannabis on a regular basis may have anti-inflammatory benefits. However, more research is needed.[3]

Effect on Cognitive Impairment. Cannabis use is associated with cognitive impairment which affects a person's performance. This altered state of mind can lead to injury that may, ultimately,

result in death. Studies have found that cannabis use immediately prior to operating a vehicle increases the risk of getting into a motor vehicle accident.

Cognitive performance (i.e., learning, memory and attention) can be impaired up to 24 hours after the use of cannabis. A few studies have found that impairments in cognitive domains may continue even after a person has stopped smoking cannabis. The lingering effects of cannabis are especially concerning for adolescents. The evidence purports that the use of cannabis during adolescence can have lasting effects on a young person's academic achievement, future employment, and social interactions and productivity.[3]

Additional Concerns Regarding Children. In states where recreational cannabis has been legalized, the evidence indicates that children have an increased risk of unintentional adverse effects (e.g., respiratory distress). There are other concerns such as low birth weight. Studies have found that maternal recreational cannabis use during pregnancy is associated with low birthweight babies. More research is necessary to determine the association of cannabis use and other pregnancy and childhood outcomes.[3]

Mental Health Issues. Studies have found that the use of cannabis increases the risk of developing schizophrenia and other psychoses. The risk of developing a mental health issue increases with the dosage. Conversely, individuals with schizophrenia and other psychoses prior to using cannabis may experience better performance on learning and memory tasks when they use cannabis. Studies have found bipolar disorder is an exception to this observation. Individuals diagnosed with bipolar disorder who use cannabis daily may experience intensified symptoms as compared to those diagnosed with bipolar disorder who do not use cannabis.[3]

Other mental health illness studies include depression, anxiety, suicide and posttraumatic stress disorder (PTSD). There is evidence that heavy cannabis users are more likely to report thoughts of suicide than non-users, and individuals that use cannabis regularly have an increased risk of developing social anxiety disorder. There is a lack of evidence that cannabis use increases the likelihood of developing other types of anxiety disorders, depression, or PTSD.[3]

Cannabis Addiction and Abuse of Other Substances. As individuals increase their frequency of cannabis consumption, there is a corresponding increased risk of becoming addicted to the substance. Additionally, it has been found that individuals who begin using cannabis at a young age are at an increased risk of developing an addiction to cannabis. Cannabis use has also been linked to an increased risk of an individual abusing other substances.[3]

Clinical Features of Cannabis Intoxication

Regardless of the positive and negative aspects of cannabis use, it is important to understand and recognize the clinical manifestations of cannabis intoxication. Similar to alcohol intoxication, cannabis intoxication can influence an individual's behaviors, perceptions and interaction with others. For example, a person experiencing cannabis intoxication may have a heightened sociability and sensitivity to certain stimuli (e.g., colors, music), altered perception of time, and an intensified appetite for sweet and fatty foods. Some users report feeling relaxed or experiencing a sensation described as a "rush" or "buzz" after smoking cannabis.[3] Such effects may be accompanied by decreased short-term memory, dry mouth, and impaired perception and motor skills. Other concerns regarding cannabis use focus on public safety. In light of the current trend in legalizing cannabis for medicinal and recreational use, the potential for impaired driving due to acute intoxication is a genuine threat to public safety.

Acute cannabis intoxication has several major contributors. One of the key contributors is tetrahydrocannabinol (THC), a compound found in the cannabis plant that stimulates cells in the

brain and cause psychological effects.[4] In incidents where a person using cannabis may have high blood levels of THC, the person may experience panic attacks, paranoid thoughts and hallucinations. In addition to the dosage of THC in a person's system, two other key factors that impact the intensity and duration of intoxication due to cannabis use are (1) individual differences in the rate of absorption and metabolism of THC, and (2) the loss of sensitivity to THC's effects.[3] Studies as synthesized in the Academies' report have found that "prolonged CB1 receptor occupation as a consequence of the sustained use of cannabis can trigger a process of desensitization, rendering subjects tolerant to the central and peripheral effects of THC and other cannabinoid agonists."[3] In studies conducted with animals, recurrent exposure to THC resulted in decreased CB1 receptor levels and connections between CB1 and its transducing G-proteins were compromised. Similar results were found in humans. In one study, researchers used imaging to study the brain of humans who were considered chronic cannabis users and found a down-regulation of CB1 receptors in the cortical regions of the brain.[3]

Decriminalization of Cannabis Use

There has been a recent trend in states legalizing cannabis use for medical as well as recreational purposes. What once was criminalized is now becoming legal and acceptable in society. Public opinion appears to be the primary influence for many of the policy changes.

A new survey, conducted by Pew Research Center from April 5-11, 2021 shows an overwhelming share of U.S. adults (91%) say either that cannabis should be legal for medical and recreational use (60%) or that it should be legal for medical use only (31%). Fewer than one-in-ten (8%) say cannabis should not be legal for use by adults.[5]

More than two in three Americans (68%) support legalizing cannabis. Gallup has documented increasing support for legalizing cannabis over more than five decades, with particularly sharp increases occurring in the 2000s and 2010s.[6]

State and National Policies

Currently, states are the main players in changing policy regarding cannabis for medicinal and recreational use. As of January 2022, 36 states, the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands have approved comprehensive, publicly available cannabis for medicinal and recreational use.[2] Some states have broad laws regarding medicinal use, others have stricter laws that limit access, and then there are those states that still criminalize cannabis use, but may allow for a legal defense under specific circumstances.[7]

State Broad Policies. In states with broad policies, access to cannabis for medicinal and recreational use is restricted to a specific population or condition/illness. Patients may access medical cannabis as their physician deems necessary. Many people may view this approach as de facto legalization of cannabis for recreational use.[2]

State Restrictive Policies. States that have implemented restrictions to access typically require patients to meet certain qualifying criteria before permitting them access. The states may also restrict the types of medical products available to patients. Such states like New York do not allow patients to smoke cannabis, but they may have access to tinctures, oils, concentrates, and other similar products.[2]

Other states may have non-THC (tetrahydrocannabinol) policies which require products to have no-THC or low-THC/high-CBD (cannabidiol) such as CBD oil. Oftentimes, the states that have no-THC policies have exceptions to the law that can be used as a legal defense.[2]

State Policies – Production & Distribution. Not only do states have different policies on the recommendation/certification of cannabis products, but also, different policies on the production and distribution of products. For example, some states regulate the establishment and operation of dispensaries (storefronts). Patients with physician recommendation/certification may visit these dispensaries to obtain a wide array of cannabis products. Some dispensaries are allowed to advertise their products and services to patients, while others may promote their services to the broader general public. In other states, only patients and caregivers may cultivate cannabis solely for the purpose of using it as prescribed within their homes. Yet, there are other states that strictly prohibit the supply and distribution of any cannabis products.[2]

Federal Law. Unlike the states, the federal government has not implemented any national laws legalizing cannabis use nor have they challenged any laws implemented by the states. Congress failed to pass federal legislation legalizing cannabis in 2021, including the Cannabis Administration and Opportunity Act and The Marijuana Opportunity Reinvestment and Expungement Act. However, a "compromise" bill, the States Reform Act, introduced in November 2021, would give individual states the full authority to regulate or prohibit cannabis. As a result, cannabis would be descheduled under the Controlled Substances Act.[8]

Existing AOA Policy and Previous Considerations

The American Osteopathic Association (AOA) has adopted a policy supporting well-controlled clinical studies on the use of cannabis and related cannabinoids for patients who have significant medical conditions for which current evidence suggests possible efficacy; and encouraging the National Institutes of Health (NIH) to facilitate the development of well-designed clinical research studies into the medical use of cannabis. (H424-A/2021).

The AOA also has policies governing the impaired behaviors of practicing physicians. These policies, listed below, broadly apply to physicians and non-physicians who are experiencing impairment resulting from use of any mind-altering substance, including cannabis.

H407-A/16 OPERATOR INTOXICATION/ IMPAIRMENT
H331-A/18 PHYSICIAN HEALTH ASSISTANCE
H424-A/21 MEDICAL CANNABIS – RESEARCH ON POLICY STATEMENT
H628-A/18 CANNABIS RECLASSIFICATION: EFFECT ON RESEARCH

AOA Policy

As cannabis decriminalization moves forward, there is a greater need to educate health professionals about the evidence-based benefits and risks of cannabis use for both medicinal and recreational purposes. All policies should focus on assuring that the public health threat of cannabis is minimalized and that the benefit of the drug, where indicated by evidence, is available to patients in need.

Physicians and students using cannabis for medicinal and recreational use will suffer cognitive impairment. Critical thinking, key to the ability to diagnose and treat patients, will be affected and patient safety will be jeopardized. Furthermore, though studies suggest cognitive dysfunction associated with cannabis use continues even after cessation of cannabis use, the duration of the impairment cannot be known. More empirical research is needed to clarify and quantify the overall impact of cannabis use and develop recommendations for use.

The American Osteopathic Association (AOA) adopts the following policies:

1. The AOA does not recommend any use of cannabis by physicians and medical students because of patient safety concerns.

2. The AOA does not support recreational use of cannabis by patients due to uncertainties in properties, dosing, and potential for impairment. Recreational cannabis use is legal only as determined by specific state law.

3. The AOA recognizes that the use of cannabis is an evolving field of research, and thus, encourages the NIH and other research entities to conduct research on the effects of cannabis use on cognition as well as the public health implications of cannabis use.

4. The AOA shall review its policy in light of any new evidence that will be generated by research entities and update this policy as necessary.

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Source: H428-A/22

Status: 2017; 2022 Reaffirmed as Amended

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Harm Reduction Modalities for People Who Inject Drugs
White Paper

Policy Statement

H429-A2022 Harm Reduction Modalities for People Who Inject Drugs (PWID) White Paper

INTRODUCTION

In 2019, 36,801 people received an HIV diagnosis in the United States (US) and dependent areas. From 2015 to 2019, HIV diagnoses decreased 9% overall in the US and dependent areas. In 2019, people who inject drugs (PWID) accounted for 7% (2,508) of the 36,801 new HIV diagnoses.[1]

The recent epidemic of prescription opioid abuse has led to increased numbers of PWID. In 2019, nearly 50,000 people in the US died from opioid-involved overdoses. The misuse of and addiction to opioids, including prescription pain relievers, heroin, and synthetic opioids such as fentanyl, is a serious national crisis that affects public health as well as social and economic welfare.[2]

Behaviors such as sharing needles, syringes, and other injection equipment cause PWID to be at high risk for contracting and transmitting HIV, viral hepatitis, and other infections.
To mitigate the impact of injection drug use and its associated consequences, communities across the US and abroad are considering harm reduction approaches, such as needle exchange programs and safe injection facilities. The goal of this paper is to discuss the benefits and risks of implementing such interventions, and to present the American Osteopathic Association's (AOA's) position on harm reduction as an approach for impacting the consequences of substance abuse among PWID.

PUBLIC HEALTH SIGNIFICANCE

According to the CDC, 1.2 million people in the US are living with HIV at the end of 2019. Of those people, about 87% knew they had HIV.[3]

PWID represent a significant percentage (13.8%) of persons living with HIV (PLWH) as well as those newly diagnosed with HIV (7%). HIV-negative persons who inject drugs have a 1 in 160 chance of contracting HIV each time they share a needle with an HIV-positive person.[4]

In addition to being at risk for HIV and viral hepatitis, PWID can have other serious health problems, like skin infections and heart infections. People can also overdose and get very sick or even die from having too many drugs or too much of one drug in their body or from products that may be mixed with the drugs without their knowledge (for example, fentanyl).[4]

Addressing the burden of HIV and hepatitis C virus (HCV) requires facilitation of multiple public health strategies aimed at interrupting disease transmission and reducing risk of acquiring and transmitting HIV, hepatitis B virus (HBV), HCV, and other blood-borne infections.[5]

Strategies to interrupt disease transmission for PWID include evidence-based practices of promoting the use of sterile needles or syringes for every injection, as well as ensuring access to medical treatment, behavior-change counseling, and addiction treatment services.[6]

Injection drug use carries the consequence of inflicting considerable harm on PWID themselves and to society. As communities develop methods of reversing increasing mortality trends, public health officials, as well as federal, state, and local organizations are exploring harm reduction interventions aimed at preventing overdose deaths, interrupting disease transmission, and alleviating harm to people misusing drugs and their families.

HARM REDUCTION PHILOSOPHY AND APPROACHES

With respect to illicit drug use, harm reduction refers to a public health approach consisting of policies, programs, and practices directed at reducing the harms associated with the use of mind-altering drugs. The defining element is prevention of harm, rather than abstinence or prevention of drug use, and its targets are people who continue to use drugs and are at elevated risk for contracting and spreading diseases. [7]

Though components of it can be traced back to the early 1930's, the term 'harm reduction' gained popularity in the mid-1980s. As awareness grew about high incidences of HIV among PWID in many countries, European cities began pioneering interventions such as needle and syringe programs. During the 90's, harm reduction strategies gained acceptance around the world, and by 2000 they were vital components of drug policy guidance from the European Union. By 2009, 31 European countries provided needle/ syringe programs (NEP, NSP) and opioid substitution therapy (OST), or at least supported them by policy. Harm reduction in prisons was also established during this period with six countries offering needle and syringe exchange programs, and 23 providing OST. Europe was also a pioneer in establishing drug consumption rooms (DCR), opening nearly all of the DCRs in the world. Due in part to the efforts of Europe, harm reduction is now official policy of the United Nations. [8]

Rooted in the concept of harm reduction is the principle that drug use for some people is inevitable because they are either unable or unwilling to abstain. In the 2019 National Survey on Drug Use and Health, for example, 40% of illicit drug users who had not entered treatment responded that they simply were not ready to commit to stopping their drug use.[9]

To effectively serve people in different phases of addiction and abuse, harm reduction ideally involves multiple simultaneous interventions customized for locality and need. For example, a harm reduction package may be comprised of opioid substitution therapy, needle and syringe programs, drug consumption rooms and counseling services. They may also include peer interventions and advocacy for funding or policy change. Needle and syringe programs are generally at the center of harm reduction interventions targeting PWID. [10]

NEEDLE-SYRINGE SERVICE PROGRAMS

The Centers for Disease Control and Prevention define Syringe Service Programs (SSPs), also referred to as syringe exchange programs (SEPs), needle exchange programs (NEPs) and needle-syringe programs (NSPs), as "…community-based programs that provide access to sterile needles and syringes free of cost and facilitate safe disposal of used needles and syringes."[11]

The first NEP was established in Amsterdam in 1983 in an attempt to quell a hepatitis B outbreak. Other European countries followed suit after the presentation of HIV/AIDS.[12]
The first SSP in the US was in New Haven, Connecticut in 1987. The program operated underground because of laws which made possession of drug paraphernalia illegal. In many

states this is still the case. The first SSP to receive public funds opened in 1988 in Tacoma, Washington. Just 2 years later, in Hawaii, the first state approved SSP was signed into law.[12] Throughout the world, harm reduction implementation has not improved since 2018. The number of countries where NSPs are available remained at 86.[12]

In addition to providing sterile needles, syringes, other drug preparation equipment, and disposal services, SSPs offer clients a range of other services. Many programs provide health education and counseling, immunizations, access to substance abuse and mental health treatment, screening for tuberculosis, hepatitis, HIV and other sexually transmitted infections (STIs), and condom distribution, as well as referrals for social services and medical programs. Programs may also be equipped with naloxone to reverse opioid overdoses.[13]

The US has experienced an increase in drug injection. Of particular concern are persons who escalated to injecting prescription opioids and heroin after using oral analgesics. Much of this activity has been identified in suburban and rural areas. HCV and HIV infection in these nonurban areas correlate with noted injection patterns and trends.[14]

HISTORY OF THE BAN ON FUNDING NEEDLE EXCHANGE PROGRAMS

With the advent of the "War on Drugs" in 1988, the US Congress implemented a ban on the use of federal funds to support syringe exchange. During the 1990s, however, an Institute of Medicine panel recommended that the federal prohibition of NSPs be revoked. The idea was supported by findings that NSPs contributed to lowered HIV incidence and did not amplify injection drug use. The Centers for Disease Control and Prevention also assessed NSPs and concluded that they were effective in halting the spread of HIV among PWID. Based on these endorsements, it was anticipated that the ban would be repealed, but President Clinton chose not to pursue changes to the federal law.[15]

In December 2009, President Obama signed the Consolidated Appropriations Act of 2010. Though this act gave states permission to fund SSPs with federal dollars, there was no money specifically earmarked. One year later, however, in December of 2011, Congress restored the ban, reversing the 2009 decision.[15]

Precipitated by the HIV outbreak in Indiana, along with sharp increases in rates of injection drug use across the country, Kentucky and West Virginia legislators championed the addition of language into an omnibus spending bill to revoke the ban. The bill was passed by Congress at the end of December 2015. The modified law is theoretically a partial repeal. Through the Consolidated Appropriations Act of 2016, states were given the ability to use federal dollars to finance SSP operations, including staffing, automobiles, gas, leases, and other operating expenses. The purchase of sterile needles and syringes is still prohibited, but funds may be used to support comprehensive services for PWID.[15]

The Consolidated Appropriations Act of 2018 permits the use of funds from the Department of Health and Human Services (HHS), under certain circumstances, to support SSPs. However, HHS funds may not be used to purchase needles or syringes.[16]

PERCEIVED RISKS OF NEEDLE-SYRINGE EXCHANGE PROGRAMS

Antagonists of NSPs in the US have primarily focused on three ideological and moral arguments for justifying prohibition. The first argument is that federal funding of NSPs would signal governmental acceptance of illegal drug use, conflicting with law enforcement efforts. The second argument is that federal funding of NSPs could encourage drug abuse and jeopardize public health and safety by facilitating Injection Drug Use (IDU), increasing the circulation of contaminated

needles, and increasing crime. The third argument is that federal approval of needle and syringe exchange programs could cause children to believe that drug use is acceptable.[15] However, studies have shown these concerns to be largely unfounded.

The US government authorized several reports to evaluate outcomes of NSPs. Key report authors were: 1) the National Commission on AIDS; 2) the US General Accounting Office; 3) the Centers for Disease Control/University of California; and 4) the National Academy of Sciences. The reports reinforced the advantages of NSPs and did not indicate any negative outcomes. The studies affirmed that when barriers such as criminalization laws regarding the purchase and possession of IDU equipment are eliminated, PWID are less likely to share needles. The reports further concluded that NSPs do not increase drug use among program participants, nor do they lead to the recruitment of new drug users.[17]

As a potential threat to public safety, the concern of improper disposal of needles has been widely studied. This perspective assumes that PWID will not return needles to distribution sites, and will, therefore, potentially endanger the health of the surrounding community by exposing residents to contaminated needles. However, successful rates of return of used needles have been documented. In her meta-analysis, study author Kate Ksobiech reviewed needle return data from 8 studies, comprised of 26 articles. Ksobiech calculated an overall worldwide return rate of 90%, though there was great variability at individual sites. Return rates for U.S. NSPs were comparable to those of international programs. One limitation noted in the study, however, is that researchers could not confirm where the needles originated, nor could they ascertain if people returned their own needles or those of their social network.[18]

Additionally, the World Health Organization has concluded that there is no evidence that NSPs negatively impact PWID, their communities, or society at large. “Studies have searched for and found no convincing evidence of the following unintended complications associated with needle and syringe exchange programs: greater injection frequency, increased illicit drug use, a rise in syringe lending to other IDUs, recruitment of new IDUs, social network formation, greater numbers of discarded used needles, less motivation to change, i.e., reduce, drug use and increased transition from non-injecting drug use to IDU.”[19]

Needle and syringe exchange sites are not always accessible to people when they need them. As a result, some PWID collect and exchange high volumes of used needles and then sell the clean ones to their peers. This black market has been identified as an unintended consequence of NSPs in some rural and scarcely resourced areas and underscores the need for more substance abuse services and IDU resources in these communities.[20] Little if any research has been conducted on the effects of black-market needles on injection drug use and HIV transmission.

Also of note, while NSPs are found to be effective in reducing HIV transmission and injecting risk behaviors among PWID, evidence regarding their impact on reducing HCV infection has been inconclusive.[21]

BENEFITS OF NEEDLE- SYRINGE EXCHANGE PROGRAMS

The most notable benefit of NSPs is that they lead to a reduction of morbidity and disease transmission, which translates to a reduction in associated health care costs. However, there are many other documented benefits. NSPs also promote public health and safety, connect PWID to substance abuse treatment programs, and provide an entry point into other health services, such as HIV and STI testing and care and treatment programs.[14]

- **Interruption of Disease transmission**

In their systematic review, Bramson, Des Jarlais et al found positive associations between publicly funded NSPs, low HIV incidence, low absolute numbers of new HIV diagnoses, and greater service provision. The study concluded that the distribution of large numbers of needles and syringes was causal, indicating that public funding of NSPs leads to lower HIV incidence. When NSPs and over the counter sales of syringes are consistently funded, they are impactful in reducing HIV transmission.[22]

According to the CDC, "Nearly 30 years of research has shown that comprehensive SSPs are safe, effective, and cost-saving, do not increase illegal drug use or crime, and play an important role in reducing the transmission of viral hepatitis, HIV and other infections."[13]

- **Linkage to Care and Services**

Many SSPs link PWID to key services and programs, such as HIV care and treatment, pre-exposure prophylaxis (PrEP), and post-exposure prophylaxis (PEP) services; hepatitis C treatment, hepatitis A and B vaccinations; screening for STI's and tuberculosis; partner services; prevention of mother-to-child HIV transmission; and other medical, social, and mental health services.[3] Given the availability of new treatments that effectively cure HCV, linking PWID to HCV and HIV testing and referring those diagnosed to care and treatment may be the most significant services offered.[14]

The majority of SSPs offer referrals to medication-assisted treatment. New SSPs users are five times more likely to enter drug treatment and three times more likely to stop using drugs than those who don't use the programs.[14]

- **Reduction in Health Care Costs**

According to the CDC, "SSPs reduce health care costs by preventing HIV, viral hepatitis, and other infections, including endocarditis, a life-threatening heart valve infection. The estimated lifetime cost of treating one person living with HIV is more than $450,000. Hospitalizations in the U.S. for substance-use-related infections cost over $700 million each year. SSPs reduce these costs and help link people to treatment to stop using drugs."[23]

- **Promotion of Public Health and Safety**

In communities where IDU is prevalent, residents are understandably concerned about unsafe disposal and circulation of potentially contaminated needles and syringes because inadvertent contact could lead to infection. SSPs address this issue by removing used needles from circulation and educating their clients about safe disposal of used syringes.[13]

Evidence demonstrates that SSPs do not increase illegal drug use or crime. Studies in Baltimore and New York City have found no difference in crime rates between areas with and areas without SSPs. In Baltimore, trends in arrests were examined before and after a SSP was opened and found that there was not a significant increase in crime rates. The study in New York City assessed whether proximity to a SSP was associated with experiencing violence in an inner-city neighborhood and found no association.[13]

- **Protection of Law Enforcement Personnel from Needle Stick Injuries**

In the course of duty, police officers are in danger of needle stick injuries, placing them at risk of becoming infected with hepatitis B, hepatitis C and HIV. Risk factors include working evening shifts, performing pat-down searches, being on patrol duties, and being a less experienced officer.

Studies show that SSPs provide safe needle disposal and reduce the number of needles in the community which protects first responders and the public. Data from CDC'S 2015 National HIV Behavioral Surveillance System showed that the more syringes distributed at SSPs per PWID in a geographic region, the more likely PWID in that region were to report safe disposal of used syringes.[13]

SAFE INJECTING FACILITIES

Safe injection facilities (SIF) are known by many names, including Safe(r) injection Sites (SIS), drug consumption facilities (DCF), Medically Supervised Injection Centers (MSIC), and Safer or Supervised Injection Facilities (SIF). They are part of a harm reduction approach to IDU. At these sites, users of illicit drugs have access to disinfecting agents and clean needles, as well as medical professionals. These legally sanctioned facilities provide a safe environment without the threat of arrest, and it provides them with access to professionals that can offer advice and refer them for rehabilitation services.[10] SIFs are not "shooting galleries", which are illegal injecting facilities run by drug dealers.[24] SIFs are managed by medical professionals, such as nurses and social workers, and drug sales are prohibited.[25]

Government sanctioned SIFs came into operation in Europe in the mid-1980s; the first of these facilities was established in Switzerland in 1984. Other SIFs existed in the Netherlands prior to this era, but they were not government sanctioned. In Germany, government sanctioned SIFs came into operation in the early 1990s, but government funding and approval was not obtained until later in 2000. Australia has attempted to open three non-government sanctioned SIFs in the late 1990s; one facility was legally approved in 2001.[24]

In December 2021, New York City opened the nation's first overdose prevention center pilots. The Drug Policy Alliance and its allies advocated for many years to reach this milestone.[25]

In July 2021, Rhode Island authorized a two-year pilot program to establish "harm reduction centers" where people can consume pre-obtained substances under the supervision of trained staff, becoming the first state to do so.[25]

There are various models of SIFs, however, the core services are generally the same:

- Provision of sterile injecting equipment;
- Medical supervision of injections, including emergency response to drug overdoses;
- Injection-related first aid (such as wound and abscess care); and
- Assessment and referral to primary health care, drug treatment and social services.[23]

ADVANTAGES OF SAFE INJECTING FACILITIES

There are many benefits associated with this kind of intervention. These benefits include allowing PWID to inject in a clean environment without having to rush, allowing PWID to have access to medical staff that are able to respond to overdoses and prevent deaths, and easy access to clean IDU equipment. The success rate of reduction of overdose deaths in safe injecting facilities is very high. SIFs aid public health by controlling the spread of disease and improving the quality of life for PWID.[24]

A systematic literature review performed via PubMed, ScienceDirect, and Web of Science databases found seventy-five articles whose study results converged to find that SIFs were most effective in attracting marginalized PWID, providing access to primary health care, reducing the frequency of overdoses, and providing safer conditions for injection. There was no evidence indicating an increase in drug trafficking, drug use, nor crime in the areas surrounding the SIFs. There was a positive correlation between the presence of SIFs, reduced amounts of abandoned

syringes, and reduced levels of public drug injections. The majority of referenced articles originated in Vancouver and Sydney.[26]

OPPOSITION TO SAFE INJECTING FACILITIES

Common objections to the establishment of facilities such as SIFs, SISs, drug consumption rooms (DCRs), and other harm reduction programs include the fear that these facilities would attract more drug users to that area, encourage youths to use drugs, and increase drug use rates. Even though the evidence previously presented along with other evidence has not supported these beliefs, these views still have a large influence on the public's beliefs about the effects of these facilities on their communities.[23]

CONCLUSION

As of 2018, there are approximately 3,864 new HIV infections among PWID per year in the US.[4] HIV, HCV, overdose, STIs, soft tissue infections, tuberculosis, and substance use disorders are among the many health problems facing PWID. Harm reduction interventions such as NSPs, opioid substitution therapy, and SIFs have demonstrated potential to reduce morbidity, mortality, and disparities among vulnerable individuals, decrease costs associated with injection drug use, and diminish harm sustained by PWID and their communities. However, public funding is necessary to provide effective, comprehensive services for this population.

State and local funding is only possible in areas with favorable syringe exchange policies. Fully repealing the ban on the use of federal funds for harm reduction interventions would provide additional funding to programs and enhance overall impact. IDU has been an important factor of HIV transmission in the US. Public funding of NSPs is strongly associated with both reducing HIV transmission among PWID in states that experienced high HIV incidence, and with maintaining low HIV in other states. Increased, consistent state and local public funding of NSPs and other harm reduction strategies, in addition to federal funding, would be a significant step forward. [22]

AOA POLICY

Given the research demonstrating the effectiveness of harm reduction strategies, such as syringe service programs (SSPs) and supervised injection facilities, in reducing HIV transmission, along with endorsements of the World Health Organization (WHO), US Centers for Disease Control and Prevention (CDC), and the Institute of Medicine (IOM), the American Osteopathic Association (AOA) adopts the following policy statements as its official position on the use of harm reduction strategies to combat the consequences of injection drug use:

1. The AOA supports the decriminalization of harm reduction strategies, such as syringe service programs (SSPs) and supervised injection facilities. Such services should be legally provided and paired with more comprehensive services, such as substance abuse and mental health counseling and treatment.

2. The AOA shall advocate for the increased availability of harm reduction modalities including safe injecting facilities and supervised injection facilities at the local, state, and federal level.

3. The AOA strongly encourages state medical associations to initiate state legislation that decriminalizes drug paraphernalia possession and procurement so that injection drug users can obtain needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.

4. The AOA is in favor of complete repeal of the ban on federal funding for syringe exchange programs.

5. The AOA is in favor of syringe service programs and encourages physicians to provide patients with education on such programs.

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Source: H429-A22

Status: 2017; 2022 Reaffirmed as Amended

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Medication For Indigent Patients

Policy Statement

The American Osteopathic Association supports the donation of non-expired medications for distribution to indigent patients on the basis of financial need.

Source: H430-A22

Status: 2001; 2006 Reaffirmed as Amended; 2011 Reaffirmed; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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AOA Policies on Opioids and Substance Use
White Paper

Policy Statement

Background on the issue

Opioid addiction and abuse continues to be an urgent public health crisis. Based on 2019 data, an average of 38 people died each day from overdoses involving prescription opioids, totaling more than 14,000 deaths. For the 12-month period ending in December 2020, provisional data from the Centers for Disease Control and Prevention (CDC) indicates that the number of overdose deaths rose to 93,331. This number is the highest ever recorded for overdose deaths in a 12-month period. Opioids were involved in approximately 75% of these deaths.[1]

Over the last few years, drug overdose deaths involving synthetic opioids and methamphetamine have shifted geographically.[2]

- From 2018 to 2019, the largest increase in death rates involving synthetic opioids occurred in the West (67.9%). Previously, the highest increases in deaths involving synthetic opioids occurred in the East.

- The largest increase in death rates involving psychostimulants occurred in the Northeast (43.8%) compared to the Midwest which had the highest increases in the past.

- No state had a significant decrease from 2018-2019.

In July 2021, the AOA House of Delegates directed the AOA Bureau of Osteopathic Research and Public Health to combine all AOA policies on opioids and substance use disorders into a comprehensive white paper. The following paper includes AOA policy statements on opioids and substance use disorders. Policies are divided into the following categories: Education on Substance Use Disorders, Education on Opioid Use and Abuse, Access to Treatment, and Diversion.

Education on Substance Use Disorders

1. The American Osteopathic Association (AOA) will advance knowledge and understanding of appropriate use of prescription drugs and TREATMENT OF substance use disorders through the education of the public and osteopathic medical education at all levels.
2. The AOA encourages its members to maintain current knowledge of addictive substances with a high potential for abuse and appropriate treatment techniques. The AOA urges all

members of the osteopathic profession to participate in the prevention and rehabilitation of persons suffering from substance use disorder and the disease of addiction.
3. The AOA will work with other associations representing health care professionals to educate on the indicators of potential prescription drug abuse, misuse, and diversion.
4. The American Osteopathic Association (AOA) encourages communities to work collaboratively with law enforcement agencies to implement evidence-based referral resources and advocate for Medication Assisted Treatment (MAT) programs as the most clinically effective and cost-effective intervention for sustained recovery, and reduction of criminal activity and mortality.

Education on Opioid Use and Abuse

1. The AOA will advocate for medical education for all practitioners on proper opioid prescribing practices and any state mandated pain education requirements should include proper prescribing practices for opioids relating to pain treatment, opioid addiction, and identification of prescription drug abuse, misuse, and diversion.
2. The AOA encourages osteopathic physicians whose practice includes the prescribing of Extended Release-Long Acting (ER/LA) Opioids to complete ER/LA Opioid Risk Evaluation and Mitigation Strategy (REMS) training to ensure that ER/LA opioids are prescribed, when indicated, in a manner that enhances patient well-being and does not contribute to individual or public harm.

Access to Treatment

1. The AOA will not support any program which limits access to prescription drugs for patients with legitimate need and will not support any program which reduces the provider's ability to inform the patient's care. In addition, it is in the best interest of all patients not to confine, or seek to regulate medications, including opioid/opiate, by limiting their use to a small number of selected specialties of medicine. This would also extend to modalities now developed, or yet to be developed, such as long-acting opioid/opiate preparations. These exclusionary strategies will limit access for patients with medical indications for therapy, complicate delivery of care, and add to pain and suffering of patients.
2. The AOA supports policies that do not hinder patient access to and coverage of appropriate pharmacologic and non-pharmacologic treatments. It is a right of all patients to have access to medically appropriate intervention and/or treatment for conditions, including acute and chronic pain. It is the right of all physicians, to provide medically appropriate intervention and treatment modalities that will achieve safe and effective treatment, including pain control, for all their patients.
3. The AOA opposes the imposition of administrative or financial deterrents that decrease access to and coverage of prescription drugs with abuse-deterrent properties.
4. The AOA will advocate to states to not lower opioid addiction treatment numbers below the 275 maximum patient load allowed under the Comprehensive Addiction Recovery Act.

5. The AOA will support the administration and/or prescribing of all FDA-approved treatments for opioid use disorder (OUD) for all individuals with OUD who are incarcerated or under other forms of governmental or private correctional control.

Diversion

1. The AOA will advocate for evidence-informed use of state prescription monitoring programs, tamper resistant drug formulas and support efforts to assist state osteopathic medical associations in developing physician drug abuse, misuse and diversion awareness and prevention education programs.
2. The AOA supports an integrated national opioid database that allows prescribers, dispensers, or their designated staff in any state to access a patient's prescription history, regardless of their residing state at no cost to the prescriber or dispenser.
3. The AOA will continue to cooperate with the pharmaceutical industry, law enforcement, and government agencies to stop prescription drug abuse, misuse and diversion as a threat to the health and well-being of the American public.
4. The AOA will encourage the Institute of Medicine and other private and public organizations/agencies to conduct further research into development of reliable outcome indicators for assessing the effectiveness of measures proposed to reduce prescription drug abuse, misuse, and diversion.

References:

1. FDA. “Online Opioid Summits.” https://www.fda.gov/drugs/news-events-human-drugs/online-opioid-summits. (Accessed 2-9-2022)
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Background Information: Provided by AOA Staff

Current AOA Policy:

The white paper is based on the following current AOA policies. If this white paper is approved, it is recommended that these policies be deleted.

H203-A/18 Substance Use Disorders Education

H300-A/19 Training – Extended Release-Long Acting (Er/La) Opioid Risk Evaluation And Mitigation Strategy (Rems)

H300-A/21 Medication For Opioid Use Disorder (Moud) Availability For Incarcerated Individuals and/or Individuals Under Correctional Control Policy Statement

H322-A/20 Prescription Drug Diversion And Abuse – Education, Research, And Advocacy

H326-A/21 Pain Related Education Requirements Policy Statement

H330-A/17 Patient Load Restrictions To Increase Pharmacological Opioid Addiction Treatment Access – Abolishment Of

H331-A/17 Interstate Opioid Database

H414-A/18 Substance Use Disorder

H440-A/16 Substance Use Disorders (Sud) – Evidence Based Treatment Programs For

Source: H431-A22

Status: 2022 Reaffirmed as Amended

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Recognizing the Disproportionate Mortality from Cardiovascular Disease in the African American Population as a Public Health Issue

Policy Statement

The American Osteopathic Association (AOA) recognize the disproportionate mortality from cardiovascular disease in the African American population as a public health issue, for which greater awareness and research is needed.

Source: H434-A22

Status: 2022 Reaffirmed as Amended

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Support for Increased Crisis Intervention Team Training for Law Enforcement

Policy Statement

The American Osteopathic Association (AOA) encourages increased resources and training initiatives, such as the crisis intervention team (CIT) and other continued best practices, for law enforcement to improve patient safety and reduce negative outcomes for patients.

Source: H436-A/22

Status: 2017; 2022 Reaffirmed as Amended

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Increased Research on the Public Health Impacts of Decriminalizing Possession of all Illicit Drugs

Policy Statement

The American Osteopathic Association (AOA) encourages increased research and data collection on the public health outcomes associated with decriminalizing the possession of all illicit drugs.

Source: H437-A/22

Status: 2017; 2022 Reaffirmed

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Breastfeeding Mothers – Protecting

Policy Statement

The American Osteopathic Association (AOA) supports legislation protecting the rights of breastfeeding mothers.

Source: H400-A/23

Status: 2003; 2008 Amended; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted

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American Osteopathic Association Makes Public Statement and Develops Protocols to Prevent Sexual Abuse of Patients

Policy Statement

The American Osteopathic Association (AOA) supports implementation of comprehensive uniform protocols for adoption by all healthcare institutions and organizations to protect patients from sexual misconduct so that suspected violations are investigated and appropriately referred to legal authorities for prosecution when appropriate.

Source: H401-A/23

Status: 2018; 2023 Adopted as Amended

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Breastfeeding Exclusivity

Policy Statement

The American Osteopathic Association (AOA) supports dissemination of information by practicing physician about the health benefits associated with the duration and exclusivity of breastfeeding for six months. Additionally, the encouragement of breastfeeding should continue while adding complementary solid foods for at least one year.

Source: H402-A/23

Status: 2002; 2007 Reaffirmed; 2012; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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Cervical Cancer, Screening for

Policy Statement

The American Osteopathic Association (AOA) encourages all osteopathic physicians and students to continue to educate themselves and their patients on current guidelines related to cervical cancer screening using the PAP and/or HPV testing.

Source: H403-A/23

Status: 2013; 2018 Reaffirmed; 2023 Adopted

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Choosing Wisely Campaign

Policy Statement

The American Osteopathic Association (AOA) endorses the spirit of the “Choosing Wisely Campaign” to help disseminate information and education to patients and health care providers to make prudent decisions in the evaluation and management of medical conditions. The AOA also supports a higher level of commitment to increasing the evidence base for the effectiveness of osteopathic manipulative treatment with the ultimate goal of submitting it to be included in the campaign.

Source: H404-A/23

Status: 2013; 2018 Reaffirmed; 2023 Adopted as Amended

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Concerns in People with Housing Insecurity

Policy Statement

The American Osteopathic Association (AOA) encourage all physicians to partner with their communities to improve access to healthcare for people experiencing housing insecurity. The AOA supports, through education and advocacy, the dissemination of social and health related resources and programs that serve homeless individuals and families. The AOA supports programs that ensure delivery of primary and preventive healthcare to all underserved populations, including those experiencing housing insecurity.

Source: H405-A/23

Status: 2018; 2023 Adopted as Amended

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Disaster Preparedness Planning

Policy Statement

The American Osteopathic Association (AOA) supports the Centers for Disease Control and Prevention's (CDC) Centers for Public Health Preparedness programs established to strengthen terrorism and other emergencies by linking academic expertise to state and local health agency needs, including programs that focus on vulnerable populations such as, but not limited to, pregnant women, new mothers, infants, and the elderly.

Source: H406-A/23

Status: 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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Energy Drinks

Policy Statement

The American Osteopathic Association (AOA) supports community awareness and education regarding the effects and potential dangers of consuming energy drinks and encourages physicians to screen for the use of energy drinks.

Source: H407-A/23

Status: 2013; 2018 Reaffirmed; 2023 Adopted

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Environmental Health

Policy Statement

The American Osteopathic Association (AOA) strongly encourages the federal government to increase its efforts to promote standards which will prevent human suffering and death from environmental threats and hazards; and reaffirms its commitment to support governmental agencies' efforts in eradicating environmentally related health risks.

Source: H408-A/23

Status: 1970; 1978 Reaffirmed as Amended; 1983 Reaffirmed; 1988 Reaffirmed as Amended; 1993 Reaffirmed; 1998 Reaffirmed as Amended, 2003; 2008 Reaffirmed; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted

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Fire Prevention – Teaching of

Policy Statement

The American Osteopathic Association (AOA) supports fire prevention education.

Source: H409-A/23

Status: 1988; 1993 Reaffirmed as Amended, 1998, 2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted

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Gambling Disorder

Policy Statement

The American Osteopathic Association (AOA) supports research on gambling disorder.

Source: H410-A/23

Status: 1998; 2003 Reaffirmed as Amended; 2008 Reaffirmed; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Adopted

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Healthy Lifestyles

Policy Statement

The American Osteopathic Association (AOA) promotes guidelines for healthy lifestyles and recognizes the importance of collaboration on this topic among specialties and national organizations. A healthy lifestyle includes healthy eating, regular exercise and maintaining a healthy weight. Healthy eating is consuming a diet rich in whole, minimally processed foods. A healthy lifestyle eliminates the use of tobacco and illicit drugs, avoids the misuse of prescription medications, and limits alcohol intake. A healthy lifestyle also includes proper care for mental health, adequate sleep, stress management and encourages connection with one's community.

Source: H411-A/23

Status: 1992; 1997 Reaffirmed as Amended, 2002; 2007; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Adopted as Amended

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Healthy People 2030

Policy Statement

The American Osteopathic Association (AOA) supports “Healthy People 2030" which includes the following objectives:

1. Health Conditions
2. Healthy Behaviors
3. Healthy Populations
4. Settings and Systems
5. Social Determinants of Health

Source: H412-A/23

Status: 1998, 2003 Reaffirmed as Amended; 2008; 2013 Referred for review and comment; 2018 Reaffirmed; 2023 Adopted as Amended

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Immunizations

Policy Statement

The American Osteopathic Association (AOA) supports the Centers for Disease Control and Prevention in its efforts to achieve a high compliance rate among infants, children and adults by encouraging osteopathic physicians to immunize patients of all ages when appropriate; supports the HHS National Vaccine Implementation Plan; and encourages third-party payers to pay for vaccines and their administration.

Source: H414-A/23

Status: 1993; 1998 Reaffirmed as Amended, 2003; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Adopted

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Medication Take-Back Program

Policy Statement

The American Osteopathic Association (AOA) supports the national prescription drug take-back day that aims to provide a safe, convenient and responsible means of disposing of prescription drugs, while also educating the general public about the potential for abuse of medications; and encourages its state associations and local agencies to sponsor take-back medication days on a frequent basis but at least annually.

Source: H415-A/23

Status: 2013; 2018 Reaffirmed; 2023 Adopted

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“Opioid Overdose” Deaths in America – Epidemic

Policy Statement

The American Osteopathic Association (AOA) supports interventions to prevent opioid overdose deaths including patient education treatment of opioid use disorder (OUD) with FDA approved medications, and the normalization of take-home Naloxone for overdose reversal.

Source: H416-A/23

Status: 2013; 2018 Reaffirmed; 2023 Adopted as Amended

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Osteopathic Manipulative Treatment of Somatic Dysfunction of the Head, Safety in

Policy Statement

The American Osteopathic Association (AOA) supports public awareness of the complexity and vulnerability of the human central nervous system, and the safe intervention of physical forces to the head by the educated hands of a trained osteopathic physician. The AOA supports full disclosure to patients of all requirements for accredited education, qualifying training, and licensure of AOA recognized medical treatments including osteopathic manipulative treatment of the head; and encourages health care laws which supports the teaching of medical interventions to fully qualified professionals. The AOA believes that medical licensure is the most appropriate foundation for the practice of osteopathic medicine and surgery, including osteopathic manipulative treatment of somatic dysfunction of the head and osteopathic cranial manipulative medicine. The AOA believes that the practice of OMT for somatic dysfunction of the head and osteopathic cranial manipulative medicine requires a professional clinical diagnosis, complete medical treatment plan, professional ethics and appropriate follow-up care.

Source: H417-A/23

Status: 2013; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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Patient Education

Policy Statement

The American Osteopathic Association (AOA) supports the advancement of patient education to promote a better understanding of personal health and wellness.

Source: H418-A/23

Status: 1983,1988 Reaffirmed as Amended,1993,1998, 2003, 2008, 2013 Reaffirmed, 2018 Reaffirmed; 2023 Adopted as Amended

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End of Life Care

Policy Statement

The American Osteopathic Association (AOA) approves the white paper on end of life care.

END OF LIFE CARE WHITE PAPER

The American Osteopathic Association approves the AOA white paper on end of life care and encourages all osteopathic physicians to be familiar with end of life care;

- supports the development, distribution and implementation of comprehensive curricula to train medical students, interns, residents and physicians in end of life issues;
- urges osteopathic medical schools, and appropriate training programs to support innovative approaches to instruction in geriatric medicine and end of life care;
- encourages all osteopathic physicians to stay current with their individual state statutes on end of life care;
- supports public policies which upholds a patient's right to a Do Not Attempt Resuscitation (DNAR) and/or Allow Natural Death (AND) designation, determined by the patient or, if the patient is incompetent, by the family, attending physicians, patient advocate, and/or Durable Medical Power of Attorney (DMPOA);
- encourages all osteopathic physicians to engage patients and their families in discussion and documentation of advance care planning regarding end of life decisions;
- will work to implement policies to ensure access to hospice and palliative services for all individuals, including the developmentally challenged, children, and other special populations regardless of insurance status;
- encourages osteopathic physicians to recognize the importance of cultural diversity in perspectives on death, suffering, bereavement and rituals at the end of life, and incorporate cultural assessment into their comprehensive evaluation of the patient and family; and
- will work to identify sources of culturally appropriate information on advance directives, palliative care, and end of life ethical issues in populations served by osteopathic physicians.

AMERICAN OSTEOPATHIC ASSOCIATION END OF LIFE CARE WHITE PAPER

The osteopathic approach to care can be particularly beneficial at the end of life. Attending to the patient and family holistically is a key principle of osteopathic medicine. Osteopathic palliative care improves the quality of life of patients and their families facing serious illness, through prevention and relief of physical, psychosocial and spiritual suffering. Osteopathic palliative care utilizes many modalities of treatment including osteopathic manipulative medicine.

End of life decisions should be the result of the collaboration and mutual informing of the patient, the patient's self-defined family and health care professionals, each sharing his or her own expertise to help the patient make the best possible decision.

Adults with decision-making capacity should be informed of their choices and that they have the legal and ethical right to make their own decisions about their end of life care, including the right

to receive or refuse recommended life-sustaining or life-prolonging medical treatment. This position honors the patient's autonomy and liberty as guaranteed in the United States Constitution and the Patient Self-Determination Act. This right exists even when the physician disagrees with the patient's decisions.

Patients without decision-making capacity have the right to assurance that their previously executed instructive advance directives, such as living wills, proxy directives (Durable Medical Power of Attorney-DMPOA) and Physician Orders for Life Sustaining Treatment (POLST) will be honored to guide others in delivering their health care. It should be noted that the term "physician" may also mean "medical" in this context. Advance directives delineate treatment options selected by an individual and enable decisions to be made by reviewing these documented wishes. The principle of "substituted judgment" allows for a proxy to speak for an individual who is unable to do so, based upon close personal knowledge of the incapacitated person. The principle of "best interests" (what the reasonable and informed patient would select) is invoked if the individual's wishes are not known. The over-riding issue is not what the family or friends want for the patient at end of life, but rather what would the patient want for himself or herself. If the patient were to awaken and be able to fully understand the circumstances, what decisions would the patient make? If the answer is clear, it is unethical, except in extraordinary circumstances, not to follow the patient's wishes.

Creating advance directives (living wills or designating a Durable Medical Power of Attorney) is to be encouraged in advance of a life threatening situation with the assistance of trusted professionals. Persons holding the DMPOA/legally designated proxy should make decisions in accordance with the patient's previously expressed preferences. Living wills document the desired treatments but leave much room for interpretation when the situation doesn't match the directives, so a combination may be best. If no DMPOA/legally designated proxy has been selected and there is no state approved surrogate available and the patient has not executed an advanced directive or expressed preferences for care at end of life, then decisions should be made based on the principle of "best interests". When there is disagreement, confusion or a request for another opinion, the use of an ethics committee is to be encouraged. Quality of life should be viewed from the patient's perspective in all these decisions because quality of life can only be self-determined. Extreme caution must be exercised when trying to determine what constitutes quality of life for another person as research has shown that patients consistently assess their quality of life to be better than their caregivers believe. Unfortunately, no documentation or proxy designation can definitively prevent or curtail disagreements between family members.

Palliative care is always appropriate when patients and families are facing a life threatening illness. The osteopathic physician understands that physical suffering from pain, dyspnea and other end of life symptoms can be relieved with good osteopathic medical management. The patient may also need psychosocial and spiritual assistance to address suffering in those domains as well. Hospice and palliative care services provide invaluable benefits to families and patients. The earliest possible involvement of hospice in the end of life care of patients should be encouraged.

The existence of a medical technology does not mandate its use. A physician is not required to provide futile medical care though it may be difficult to determine that a requested treatment is actually futile. A life-prolonging treatment may allow a terminally ill patient to achieve an important life goal such as seeing a grandchild, but in other cases aggressive therapies serve only to prolong suffering and expense associated with the dying process. The physician should employ full disclosure and compassionate honesty in discussing a treatment's likely benefits

and burdens. If agreement cannot be reached, a consultation with an ethics committee is appropriate. If an ethics committee is not available, it may be necessary to seek the assistance of a court-appointed guardian. When a patient and physician cannot align their goals and treatment approaches, a congenial transfer of care may be necessary. Patient abandonment is unethical.

Withholding or withdrawing life sustaining treatments are considered morally, legally, and ethically identical because the end results are the same. When the benefit of a treatment is uncertain a time-limited trial is frequently advisable to help clarify prognosis. Offering treatment and then withdrawing it if it proves to be ineffective or burdensome is preferable to not offering the treatment at all.

Artificial nutrition and hydration may actually prolong the dying process. The use of artificial nutrition and hydration involves invasive medical procedures with potential side effects and complications. A decision to not provide or to discontinue this intervention may pose significant challenges to professional caregivers as well as to families. Physicians need to assist patients and families to understand the role of artificial nutrition and hydration at the end of life. Research has shown that dying patients do not experience hunger or thirst.

“Do Not Resuscitate/DNR” status is appropriate for patients who are dying from a primary illness or injury, or for whom cardiopulmonary resuscitation (CPR) would not be effective or for whom the burden of treatment outweighs the benefit. It is important to ensure that patients with DNR status receive all comfort care and appropriate treatments. A DNR status does not preclude treatment of correctable conditions.

“Physician-assisted suicide” is generally defined as a patient obtaining the assistance of a physician to secure the means to cause their own death. Physician-assisted suicide is legal only as determined by specific state law.

In the definition of euthanasia, someone other than the patient administers the life-ending drug. Euthanasia is illegal in all states.

While there are euphemisms for the term physician-assisted suicide (PAS), the definition of this practice makes it very clear that the patient is dying by suicide and the physician has assisted by providing the means/medication prescription.

A further complication of employing physician-assisted suicide is that the required self-administration by the patient is unavailable to the paralyzed, those with ALS, those who can’t swallow, and those with GI cancers which prevent absorption of oral medication.

The request for physician-assisted suicide is frequently a call for help. Individuals may request physician-assisted suicide for reasons other than pain, e.g., inability to cope, fear of being a burden, or lack of control. The “Oregon Death with Dignity Act – 2022 Data Summary” is a report of the 25 years of data generated from implementation of this law in the first state to enact such a law. The reasons identified by patients who did die by suicide under this law are listed in a table on page 14 of this document.[1] As shown in the table, over the 25 years of the implementation of this law, 28% of the concerns prompting ingestion of life-ending medication were due to “inadequate pain control or concern about it.” The concerns at the top of the list, at 90% each, were “less able to engage in activities making life enjoyable,” and “losing autonomy.”1 Other concerns included “loss of dignity” (71%), “burden on family,

friends/caregivers" (48%), "losing control of bodily functions" (44%), and "financial implications of treatment" (5%).[1]

The alternative to physician-assisted suicide is having physicians who are committed to providing excellence in end of life care and continuing to attend their dying patients. Community resources such as hospice programs should be made available to all patients.

Additional specific alternatives to physician-assisted suicide in dealing with issues at end of life include, voluntarily stopping eating and drinking (VSED), stopping life-sustaining therapies, proportional palliative sedation, and palliative sedation to unconsciousness.[2]

Whether or not physicians should choose to support and then participate in the practice of physician-assisted suicide is controversial. It is also a personal decision, reflecting the moral conscience and beliefs of each physician. The law in every state recognizes the personal nature of this decision for every physician and specifically does not require any physician to advocate for or participate in this practice.

Some organizations have taken an official position on this issue. Physician-assisted suicide is opposed by the American Medical Association[3], the American College of Physicians[4] and the National Hospice and Palliative Care Organization[5], the largest such member organization dealing exclusively with end of life issues. The American Association of Family Physicians6 has taken a position of "engaged neutrality." The American Academy of Hospice and Palliative Medicine (AAHPM) has taken a position of "studied neutrality." [7] The AAHPM statement goes on to add "however as a matter of social policy, the Academy has concerns about a shift to include physician-assisted dying in routine medical practice, including palliative care. Such a change risks unintended long-range consequences that may not yet be discernable, including effects on the relationship between medicine and society, the patient and physician, and the perceived or actual integrity of the medical profession." (Nota bene: The Academy uses the term "physician-assisted dying")

Legal involvement to resolve end of life conflicts is sometimes inevitable, but is usually not the approach of choice. Legislative "remedies" including single-person and single-situation laws are also inappropriate. By far, the best approach to prevention/resolution of conflict is by documented advanced planning, good communication, and the assistance of an ethics committee. Collection of "clear and convincing evidence" of the patient's wishes as cited in a US Supreme Court decision, as well as the principles of "substituted judgment" and "best interests" discussed above apply to the decision-making process.

Families of patients living with a terminal illness also have needs: the need to understand the dying process, the need to have cultural and religious differences understood and respected, the need to process grief. The osteopathic physician understands the important contribution of the family to the patient's overall wellbeing and includes the family in the palliative plan of care.

Patients living with a life threatening illness as well as those who are terminally ill have a right to relief of pain as well as relief of other physical symptoms. Fear of regulatory scrutiny should never be a deterrent to the prescription of adequate doses of analgesic medications. State licensing boards of medicine and pharmacy should provide assurance to physicians that this care is appropriate and protected under the law. Osteopathic colleges and graduate medical education programs are encouraged to review curricula in order that adequate education in osteopathic pain management is provided to osteopathic trainees at all levels of their education. Physicians in practice will want to avail themselves of educational opportunities to stay current

in pain management and other aspects of end of life care. Osteopathic physicians should always assure their patients that they will provide safe and comfortable dying. Alternatively, patients may elect to suffer significant pain so that they remain alert and engaged until death. In every circumstance, patient autonomy for decision-making must be upheld.

At the end of life, the goal is comfort for the patient and psychosocial support of the family. Osteopathic physicians, through their holistic approach, are well suited to provide quality end of life care. DOs are in a unique position to provide important leadership in enhancing end of life care in the United States. There is no finer gift that osteopathic physicians can give than to provide excellent care through all phases of life and no one is better suited to the task.

Nota bene: In an area as sensitive as end of life, no white paper can address all scenarios and permutations. It should be understood that this white paper presents general guidelines, and osteopathic physicians will always tailor appropriate management to the needs of their individual patients and families.

References

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4. Sulmasy, LS, Mueller, PS. For the Ethics, Professionalism and Human Rights Committee of the American College of Physicians, "Ethics and Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper" Ann Intern Med.2017;167:576-578.
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6. AAFP, https://www.aafp.org/news/2018-congress-fmx/20181010cod-hops.html
7. Statement on Physician-Assisted Dying. American Academy of Hospice and Palliative Medicine (AAHPM), 2016, https://aahpm.org/positions/pad Accessed March 2023.

Source: H419-A/23

Status: 2005; 2010 Reaffirmed as Amended; 2015 Reaffirmed as Amended; 2017 Reaffirmed as Amended; 2022 referred to BORPH; 2023 Adopted as Amended

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Pediatric Medical Imaging

Policy Statement

The American Osteopathic Association (AOA) supports the reduction of excess ionizing radiation exposure of the pediatric population and urges its members involved in medical imaging of pediatric patients to review the latest research and educational materials from the National Cancer Institute and other organizations and pledge to do their part to “child-size” the radiation dose used in children’s imaging.

Source: H420-A/23

Status: 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Adopted

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Pediatric Obesity

Policy Statement

The American Osteopathic Association (AOA) encourages:

1. Dissemination of research related to pediatric obesity
2. Continuing Medical Education (CME) activities addressing pediatric obesity
3. The use of evidence-based guidelines concurrent with current recommendations

The AOA encourages physicians who provide healthcare to children and adolescents to provide care and clinical recommendations to the patient and/or parent or guardian in alignment with current evidence-based guidelines and/or practices.

Source: H421-A/23

Status: 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Adopted as Amended

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Tuberculosis Medical Training

Policy Statement

The American Osteopathic Association (AOA) supports tuberculosis prevention programs carried out by the Centers for Disease Control and Prevention (CDC), The National Institutes of Health (NIH) and other organizations and encourages the use of the CDC's core curriculum on tuberculosis by osteopathic physicians who treat patients diagnosed with tuberculosis or who are at high risk for tuberculosis disease or infection.

Source: H422-A/23

Status: 1993; 1998 Reaffirmed as Amended; 2003 Reaffirmed; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Adopted

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Distracted Driving

Policy Statement

The American Osteopathic Association (AOA) supports appropriate legislation to ensure safe driving without distractions.

Source: H423-A/23

Status: 2008; 2013 Reaffirmed; 2018 Reaffirmed as Amended; 2023 Adopted

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Artificial Intelligence in Healthcare

Policy Statement

The American Osteopathic Association (AOA) studies the impact of AI in healthcare, including but not limited to:

1. The potential benefits and risks of AI in healthcare for patients, healthcare professionals, and healthcare organizations.

2. The ethical, legal, and social implications of AI in healthcare, including issues related to data privacy, bias, and transparency.

3. The impact of AI on the roles and responsibilities of healthcare professionals and the potential need for new training and education.

4. The potential impact of AI on healthcare costs and the healthcare system as a whole.

5. The potential impact of AI on the practice of osteopathic medicine.

The AOA will provide a report and action plan to the House of Delegates at its meeting in 2024.

Source: H424-A/23

Status: 2023

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Recognizing the Issue of Weight Bias in Healthcare

Policy Statement

The American Osteopathic Association (AOA) recognizes that bias suffered by individuals with overweight and obese conditions in healthcare is a public health issue. The AOA supports equitable and affordable insurance coverage for proven treatments, including the use of pharmaceuticals in the management of individuals with overweight and obese conditions. The AOA promotes greater awareness and research regarding how to reduce the implicit and explicit bias in healthcare is needed to improve the treatment and management of individuals with the diseases conditions of overweight and obesity.

Source: H425-A/23

Status: 2023

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Osteopathic Medicine is High-Value Care

Policy Statement

The American Osteopathic Association (AOA) acknowledges that osteopathic medicine, including OMT, meets the values of the Triple Aim, and represents high-value care.

Source: H426-A/23

Status: 2023

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Adopting and Promoting Non-Stigmatizing Language for Substance Use Disorders

Policy Statement

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

Source: H428-A/23

Status: 2020; 2023 Adopted as Amended

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Supporting Access to Oral Contraceptive Pills

Policy Statement

The American Osteopathic Association (AOA) stands in support of affordable access to oral contraceptive pills.

Source: H429-A/23

Status: 2023

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Employee Retirement Income Security Act of 1974

Policy Statement

The American Osteopathic Association (AOA) 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 AOA also supports legislation that extends these protections to clinical decisions impacting patient access to prescription drugs.

Source: H400-A/24

Status: 2004; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted

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Firearm Safety

Policy Statement

The American Osteopathic Association (AOA) recommends that physicians ask patients and/ or caregivers about the presence of firearms in the home and counsel patients who own firearms about the potential dangers inherent in gun ownership, especially if vulnerable individuals' children and adolescents are present.

The AOA recommends strategies such as secure storage and the use of safety locks to eliminate the inappropriate access to firearms by vulnerable individuals' children and adolescents and recommends all physicians to educate families in the safe use and storage of firearms.

Source: H401-A/24

Status: 1994; 1999 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed as Amended; 2024 Adopted

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Physician-Patient Relationship as Related to Proposed Gun Control Laws, Protection of the

Policy Statement

While the American Osteopathic Association (AOA) 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.

Source: H403-A/24

Status: 2013; 2019 Reaffirmed; 2024 Adopted

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CMS Rules on Psychotropic Medications in Nursing Facilities

Policy Statement

The American Osteopathic Association (AOA) advocates for the Centers for Medicare and Medicaid Services (CMS) to exclude hospice patients from the CMS rules for use of psychotropic and antipsychotic medication in nursing facilities.

The AOA will work with CMS to refine the rules governing the necessary 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.

Source: H404-A/24

Status: 2019; 2024 Adopted as Amended

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Community Pharmacies; Required Notification of Primary Care Providers Regarding Vaccination Administration

Policy Statement

The American Osteopathic Association (AOA) supports 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.

Source: H405-A/24

Status: 2019; 2024 Adopted

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Discrimination in Healthcare

Policy Statement

The American Osteopathic Association (AOA) adopts a zero-tolerance policy for all forms of patient discrimination.

The AOA in concert with other healthcare organizations, and the federal, state, and local governments will continue to monitor, correct, and prevent any future negative bias.

Source: H406-A/24

Status: 1999, 2004 Reaffirmed; 2009 Reaffirmed as Amended; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted as Amended

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Public Information – Correction of, About the Osteopathic Profession

Policy Statement

The American Osteopathic Association (AOA) will work with online and public information sites to ensure that content is accurate and unbiased and encourage osteopathic physicians to notify the AOA Division of Media Relations to address misinformation regarding the osteopathic profession.

Source: H407-A/24

Status: 2014; 2019 Reaffirmed as Amended; 2024 Adopted as Amended

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Comparative Effectiveness Research

Policy Statement

The American Osteopathic Association (AOA) adopts the following principles regarding comparative effectiveness research.

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, 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.

• The physician/patient relationship must be protected, and the needs of the patients should be paramount.

Source: H409-A/24

Status: 2009; 2014 Reaffirmed as Amended; 2019 Reaffirmed as Amended; 2024 Adopted as Amended

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Fluoridation

Policy Statement

The American Osteopathic Association (AOA) supports the fluoridation of fluoride-deficient public water supply.

Source: H410-A/24

Status: 2004; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted

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Lead Exposure in Children – Prevention, Detection, and Management

Policy Statement

The American Osteopathic Association (AOA) encourages physicians and public health departments to screen children for lead based on current recommendations and guidelines established by the U.S. Centers for Disease Control and Prevention's Childhood Lead Poisoning Prevention program 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 the development of effective and innovative strategies to reduce overall childhood lead exposure.

Source: H411-A/24

Status: 2014; 2019 Reaffirmed; 2024 Adopted as Amended

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Hepatitis C Screening

Policy Statement

The American Osteopathic Association (AOA) supports universal screening and appropriate periodic testing for those at risk for Hepatitis C per current CDC guidelines and supports the promotion of HCV public education programs addressing testing strategies and treatments.

Source: H412-A/24

Status: 2014; 2019 Reaffirmed as Amended; 2024 Adopted as Amended

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Vaccines

Policy Statement

The American Osteopathic Association (AOA) will continue to promote evidence-based information on vaccination compliance and safety.

Source: H414-A/24

Status: 2009; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted

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Domestic and Intimate Partner Violence – Development of Programs to Prevent

Policy Statement

The American Osteopathic Association (AOA) 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.

Source: H415-A/24

Status: 1989; 1994 Reaffirmed; 1999 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Adopted

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Alert Network – Silver and Gold

Policy Statement

The American Osteopathic Association (AOA) supports the wide-spread state adoption of emergency response systems for missing mentally impaired adults throughout the United States, via “Silver Alert” and “Gold (or golden) Alert” networks which are also known as “Endangered Person Advisory Networks.”

Source: H416-A/24

Status: 2014; 2019 Reaffirmed; 2024 Adopted as Amended

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Recognizing Food Insecurity as a Public Health Issue

Policy Statement

The American Osteopathic Association (AOA) recognizes food insecurity as a public health issue.

Source: H417-A/24

Status: 2019; 2024 Adopted

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Alcohol Abuse

Policy Statement

The American Osteopathic Association (AOA) supports local, state, and federal legislation that would control the consumption and purchase of alcohol by individuals under the age of twenty-one; and supports alcohol misuse prevention and treatment programs as a high national priority.

Source: H418-A/24

Status: 1974; 1987 Reaffirmed; 1983 Reaffirmed as Amended; 1988 Reaffirmed; 1994 Reaffirmed; 1997 Reaffirmed; 1999 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted as Amended

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Occupant Protection in Passenger Vehicles

Policy Statement

The American Osteopathic Association (AOA):

1. Supports the ongoing efforts of the national safety council and the national highway traffic and safety administration and other responsible safety organizations to educate the public regarding the proper use of all occupant protection equipment in passenger vehicles and the benefits and potential dangers of all occupant protection equipment and accident-avoidance systems.

2. Urges research and development of safer automobiles and continued monitoring of injuries and fatalities resulting from traffic accidents and faulty and/or improper use of all occupant protection devices in passenger.

Source: H419-A/24

Status: 1974; 1987 Reaffirmed; 1983 Reaffirmed as Amended; 1988 Reaffirmed; 1994 Reaffirmed; 1997 Reaffirmed; 1999 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted as Amended

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Sudden Infant Death Syndrome

Policy Statement

The American Osteopathic Association (AOA) supports continued research into the causes and prevention of sudden infant death syndrome (SIDS).

The AOA encourages the availability of information based on current medical literature to the public on the nature of sudden infant death syndrome and proper counseling to families who lose infants to this disease.

The AOA supports the U.S. Department of Health and Human Services and Centers for Disease Control and Prevention campaigns by encouraging its members to educate parents and care-givers of infants on strategies to reduce the risk of SIDS.

Source: H420-A/24

Status: 1974; 1980 Reaffirmed; 1985 Reaffirmed; 1990 Reaffirmed; 1995 Reaffirmed; 2000 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted as Amended

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Patient Safety and use for Patients with Pain Conditions

Policy Statement

The American Osteopathic Association (AOA) affirms that Osteopathic Manipulative Treatment (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.

Source: H421-A/24

Status: 2014; 2019 Reaffirmed; 2024 Adopted as Amended

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Human Trafficking – Awareness as a Global Health Problem

Policy Statement

The American Osteopathic Association (AOA) acknowledges human trafficking as a violation of human rights and a global public health problem.

The AOA 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.

Source: H422-A/24

Status: 2014; 2019 Reaffirmed; 2024 Adopted

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LGBTQIA+ Relationships and Health Families

Policy Statement

The American Osteopathic Association (AOA) recognizes the need of LGBTQIA+ households to have the same access to health insurance and health care as heterosexual/cisgender households and supports measures to eliminate discrimination against LGBTQIA+ 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 LGBTQIA+ marriages and civil unions and the children of those families.

Source: H423-A/24

Status: 2014; 2019 Reaffirmed; 2024 Adopted as Amended

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Maternal and Child Healthcare Block Grants

Policy Statement

The American Osteopathic Association (AOA) supports government expenditures for the Title V Maternal and Child Healthcare Block Grant Program and the efficient use of its resources.

Source: H424-A/24

Status: 1988; 1993 Reaffirmed; 1998 Reaffirmed; 2003 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted as Amended

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Health Care Fraud

Policy Statement

The American Osteopathic Association (AOA) 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.

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.

Source: H425-A/24

Status: 1999; 2004 Reaffirmed; 2009 Reaffirmed as Amended; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Adopted

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Automated External Defibrillator Availability

Policy Statement

The American Osteopathic Association (AOA) recommends an Automated External Defibrillator (AED) be placed in as many public places as possible and supports legislation that will limit the liability for installing an AED for use by the public.

Source: H426-A/24

Status: 2009; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted

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Enhanced Legislative Support for Behavioral and Mental Health Care

Policy Statement

The American Osteopathic Association (AOA) supports legislative and other efforts to enhance access to behavioral and mental health care resources in local communities, schools, emergency departments and urgent care facilities.

Source: H427-A/24

Status: 2024 Adopted

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Recognition of Intellectual and Developmental Disabilities as a Health Disparity

Policy Statement

The American Osteopathic Association (AOA) recognizes people with Intellectual and Developmental Disabilities (IDD) as a population with health disparities; and, that the AOA includes the IDD population in health disparity education, research, and legislative efforts to enhance health equity in this population.

Source: H428-A/24

Status: 2024 Adopted as Amended

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Artificial Intelligence in Healthcare Report and Action Plan

Policy Statement

The American Osteopathic Association (AOA) approved the Artificial Intelligence in Healthcare policy.

Artificial Intelligence in Healthcare

The use of Artificial Intelligence (AI) in healthcare has grown exponentially over the last few years. In October 2023, President Biden released a comprehensive Executive Order on the Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence which addresses AI in Healthcare.[1] In December 2023, the European Union (EU) released a draft regulation which aims to ensure that AI systems placed on the European market and used in the EU are safe and respect fundamental rights and EU values.[2] Numerous professional associations have developed policies around the use of AI in healthcare.[3, 4, 5] While AI promises great benefits to physicians and their patients, there are enormous risks if AI is not appropriately deployed.

In July 2023, the AOA House of Delegates requested that the AOA study the impact of AI in healthcare pertaining to five issues. The AOA was directed to present a report and action plan to the House of Delegates for the July 2024 HOD meeting. The five issues outlined in the resolution are presented below with accompanying commentary. The action plan/recommendations are then presented.

NOTE: Some professional associations refer to AI as Augmented Intelligence.[3] Augmented Intelligence seeks to enhance human capabilities by providing AI-powered tools and assistance. Artificial Intelligence aims to create autonomous systems that can perform tasks without human intervention. The use of the term “AI” in this document refers to both Artificial and Augmented Intelligence.

1. The potential benefits and risks of AI in healthcare for patients, healthcare professionals, and healthcare organizations.

The benefits of AI can be numerous. For osteopathic physicians and other healthcare professionals, AI can be used to assist with administrative tasks such as creating office notes, producing patient messages, and responding to document requests.[6] Other clinical applications include chart reviews, clinical decision support (CDS) tools, medical imaging analysis, development of patient resources, and research applications including literature review, document drafting, and data analysis.[7]

By removing administrative barriers for physicians, AI can benefit patients through increased time for engagement with physicians. AI can also improve patient education by providing clearer information on medical treatments which can lead to better outcomes.[8]

For healthcare organizations, AI can produce cost savings by streamlining operations, reducing inefficiencies, and enhancing resource allocation.

However, there are also numerous risks, such as generation of biased outcomes due to training on poor quality data, generation of inaccurate results through flaws in data sources used for model training, violation of patient privacy, and harm resulting from insufficient training on use of tools. One category of new technology where these risks are pronounced is in Large Language Models (LLMs). These are a relatively new type of AI that can generate text and perform other natural language processing tasks. LLMs are trained on large sets of data, such as programming languages, and can learn patterns and connections between words and phrases. Datasets used in training the LLM may be biased, out of date or otherwise flawed, which can result in the AI system producing unreliable or inaccurate information. If an LLM cannot find the correct answer to a query, it may falsify information and generate errors.[6] If not designed and implemented appropriately, AI systems can contribute to patient harm. LLMs are not currently regulated. Rules need to be developed to address data privacy, security, and transparency.

However, risks also exist in a broad range of AI technologies used in healthcare, both for treatment and in administrative functions. AI software that are "intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease…or are intended to affect the structure or any function of the body" are regulated as medical devices by the U.S. Food and Drug Administration.[9] Over 600 such tools are approved and used in clinical practice, improving patient care across the country.[10] These technologies include Clinical Decision Support (CDS), such as imaging analysis and predictive tools, as well as digital therapeutics, among other technologies. However, while these tools can significantly improve outcomes, their use also entails risk, such as biased outcomes through training on insufficient data or misuse through improper training.

Use of AI without appropriate clinician oversight may also result in liability for physicians. Physicians should be cautious with their reliance on AI tools for clinical uses.[6,11]

2. The ethical, legal, and social implications of AI in healthcare, including issues related to data privacy, bias, and transparency.

Issues of transparency, patient privacy and compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) must be addressed in AI systems to protect patient data. In the case of LLMs, a key concern is whether patient information entered into an LLM will remain secure and not subject to cybersecurity threats. It is also unclear if LLMs are covered by HIPAA. If use of patient medical information violates HIPAA compliance, this could result in penalties to physicians.[6]

Across all AI software, including FDA regulated software and other software, bias in the development of products poses a risk to patient care. AI models which are trained on biased data may increase existing biases in healthcare resulting in discriminatory outcomes.[7,12] Use of biased AI modules along with existing cultural and language barriers and bias may also worsen health outcomes for certain populations.[13] It is important to continue to provide culturally competent care to all patients with the widespread adoption of AI.

AI algorithms must be transparent and easy to interpret, so physicians and patients understand how decisions are being made. It is imperative that AI companies guarantee the confidentiality of patient data and provide policies on how data is collected, stored, and used.[4]

3. The impact of AI on the roles and responsibilities of healthcare professionals and the potential need for new training and education.

AI can automate routine tasks (such as data entry, administrative work, managing appointments and documentation) which will allow healthcare professionals to focus on patient care. Physicians and other healthcare professionals need to become more proficient in AI to understand its concepts, limitations, and ethical considerations. Training programs should cover AI applications, model interpretation, and responsible use. Combining medical knowledge with data science and technology expertise will become essential.

Medical education, training, and assessment should incorporate AI literacy moving forward.

4. The potential impact of AI on healthcare costs and the healthcare system as a whole.

Studies predict that adoption of AI in healthcare can potentially lead to reductions in spending of 5-10%.[14] As outlined in the sections above, AI adoption could also improve healthcare quality, increase patient access, enhance patient experiences, and provide greater physician satisfaction. However, it will be crucial to overcome obstacles related to data privacy, liability, bias, transparency, interoperability, and regulatory compliance, and ensure that AI use by insurers and others does not result in patient harm through delayed care or additional burden on physicians and patients

5. The potential impact of AI on the practice of osteopathic medicine.

AI is uniquely positioned to help osteopathic medicine reach its full potential, as it can remove barriers to the patient-centered, hands-on approach DOs are trained to provide. As trusted sources of health information and guidance, osteopathic physicians will play an integral role in addressing the use of AI with their patients.

Osteopathic physicians:

- Focus on understanding the patient as a complete individual including body, mind, and spirit.
- Believe there is more to good health than the absence of pain or disease and provide a holistic and comprehensive approach to treating patients.
- Support each patient in achieving a high level of wellness by focusing on physical and behavioral health and the individual's environment.[15]

The incorporation of the tenets of osteopathic medicine,[16] Osteopathic Principles & Practice (OPP), and Osteopathic Manipulative Medicine (OMM) into AI tools will ensure that the osteopathic philosophy of treatment is applied to each patient encounter. To the extent that AI can "re-humanize" medicine by reducing administrative burden and the intrusion of technology upon the physician-patient relationship, osteopathic medicine is poised to thrive in this new environment.

Action Plan/Recommendations

1. The AOA will develop a comprehensive policy paper addressing the AOA's position on use of AI in healthcare.

2. The AOA, in partnership with other osteopathic organizations, will investigate partnerships with existing AI software development companies to integrate osteopathic data, language, and terminology, Osteopathic Principles & Practice (OPP) and Osteopathic Manipulative Medicine (OMM) into mainstream AI tools.

3. The AOA will monitor new and existing federal and state regulations/legislation on AI and provide comments on AOA's positions.

4. The AOA, working with other osteopathic partners, will create educational programs, materials, and tools to assist osteopathic students, residents, and physicians with navigating AI.

5. The AOA will develop member resources addressing comprehensive data management and security protocol such as guidelines on data collection, storage, processing, and sharing, ensuring compliance with HIPAA and other relevant privacy laws.

6. The AOA will maintain a list of experts in AI (DOs and others) to provide insights to the AOA on the status of AI implementation and issues affecting the osteopathic profession as they arise.

7. The AOA will continue to monitor AI use in healthcare and advocate for appropriate human oversight at all stages of AI development and use.

8. Th AOA will provide regular updates to the osteopathic profession on the use of AI in healthcare and its impact on the osteopathic profession.

   AI Use Disclosure: Microsoft Copilot was used in the development of some sections of this report, to confirm references and, in some cases, generate additional references. All references and text produced by Copilot were reviewed and edited by AOA Staff.

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Source: H429-A/24

Status: 2024 Adopted as Amended

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Human Immunodeficiency Virus (HIV) Testing – Clinical and Public Health Application of

Policy Statement

The American Osteopathic Association (AOA) supports the U.S. Centers for Disease Control and prevention (CDC) recommendations as outlined in the policy.

The American Osteopathic Association (AOA) supports the U.S. Centers for Disease Control and Prevention (CDC) recommendations that everyone aged 13-64, receive at least one HIV test as a part of routine health care and more frequent testing, at least annually, for those at higher risk.[1] Per the CDC[2], individuals who may benefit from at least annual screening include:

- Sexually active gay or bisexual men (some of whom may benefit from more frequent testing, such as every 3 to 6 months).
- Individuals who have had sex with an HIV-positive partner.
- Individuals who have had more than one partner since their last HIV test.
- Those who have shared needles or equipment to inject drugs.
- People who have exchanged sex for drugs or money.
- Individuals who have another sexually transmitted disease, hepatitis, or tuberculosis.
- Those who have had sex with someone who has participated in any of the above activities or with someone with an unknown sexual history.

A. Healthcare Workers

1. Healthcare workers have a minimal risk of acquiring HIV infection from patients.[3,4]
2. Properly used universal precautions are effective in the prevention of transmission of bodily fluids between healthcare workers and patients and diminish the risk of infection.[3] Serologic testing of patients and/or healthcare workers for the purposes of infection control does not prevent the transmission of HIV infection nor enhance the effectiveness of universal precautions. The AOA supports and encourages patients who know they are HIV positive to inform their physician that they are HIV positive prior to receiving medical care.
3. CDC recommends that all HIV screening be voluntary, and opt-out (patient is notified that the test will be performed and consent is inferred unless the patient declines) vs. opt-in (test is offered to the patient who must explicitly consent to an HIV test, often in writing).[1, 5] The AOA opposes mandatory testing of patients and healthcare workers as there is no scientific data supporting the efficacy of such testing in the prevention of HIV transmission in the healthcare setting. The AOA affirms the right of HIV-infected individuals to practice their occupations in a manner which does not present any

identifiable risk of transmission of disease and pledges itself to promote the ability of these individuals to continue productive careers so long as they can do so responsibly and safely.

4. The AOA supports programs for effective education and implementation of universal precautions in all healthcare settings.

B. Public and Patient Education

1. Although studies have demonstrated an improved awareness of HIV infection and its modes of transmission, myths and misconceptions persist.

2. The AOA supports public education programs that provide accurate, up-to-date and clearly stated information regarding HIV transmission. The AOA urges increased governmental appropriations for implementing public health measures to assist in halting the increasing incidence of HIV and AIDS.

3. Primary care physicians fill a central role in the education of patients regarding preventative healthcare in general and are in an ideal position to serve a central role in HIV prevention.

4. The AOA encourages all osteopathic physicians to be knowledgeable in HIV risk evaluations and to incorporate candid and nonjudgmental assessment of related risk behaviors in routine patient care.

C. Medical Education

1. Osteopathic medical students and physicians in training are particularly vulnerable to the socioeconomic consequences of occupationally acquired HIV infection. The osteopathic profession bears a unique responsibility to provide for their maximum protection and social wellbeing.

2. All osteopathic medical schools and postdoctoral training programs should make available: life, health and disability insurance including coverage for occupationally acquired HIV infection; effective education and training in AIDS, infection control and universal precautions.

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Source: H430-A/24

Status: 1991; revised 1992; reaffirmed 1997, revised 2003; reaffirmed 2013; reaffirmed 2018; Referred to BORPH 2023; 2024 Adopted as Amended

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Warning the Profession and Public about the Potential Dangers of Kratom Use

Policy Statement

The American Osteopathic Association (AOA) promote learning opportunities for its members about Kratom, its current accessibility, cultural background and considerations, use by the public, and concerns regarding safety and efficacy or lack thereof.

The AOA opposes Kratom being available for marketing, purchase, or prescription until such time that the FDA and other relevant regulatory agencies evaluate its safety and appropriateness for sale.

Source: H431-A/24

Status: 2024 Adopted as Amended

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Addressing the compromised safety of Healthcare Workers practicing in areas of conflict and the resulting threat to Healthcare Infrastructure

Policy Statement

The American Osteopathic Association (AOA) affirms, the right of physicians globally to ethically practice medicine without fear of persecution or personal danger in any and all situations, including but not limited to wartime and civil unrest.

The AOA advocate for the unimpeded delivery of humanitarian aid, highlight the need for security of medical personnel across all conflict zones, and denounce the targeting of healthcare systems including the denial of medical services in conflict zones.

Source: H435-A/24

Status: 2024 Adopted as Amended

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Childhood and Teenage Sexual Exposure

Policy Statement

The American Osteopathic Association (AOA) strike preferably abstinence; and replace with including abstinence from line 11 of policy H420-A/21 Childhood and Teenage Sexual Exposure so that section (2) now reads encourages osteopathic physicians to support the development of curriculum by local, state and national educational organizations that will lead to the prevention of pregnancy and transmission of disease, using medically appropriate measures and avoidance of high-risk sexual behavior.

Source: H436-A/24

Status: 2024 Adopted as Amended

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SPECIAL MEETING OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
AD HOC - RESOLUTION ROSTER
As of September 24, 2020

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTION:

- Ad Hoc Committee (600 series)
  This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.

Res. No.	Resolution Title	Submitted By	Reference Committee
H600	Dissemination of Publications in Osteopathic Research (H600-A/15)	BOCER	Ad Hoc
H601	Reduction of Osteopathic Training Positions in Post-Graduate Medical Education (H601-A/15)	BOE	Ad Hoc
H602	Reimbursement for Physician Time Spent Obtaining Pre-Certification and Pre-Authorization (H602-A/15)	BSA	Ad Hoc
H603	Pay for Performance (H604-A/15)	BSA	Ad Hoc
H604	Proper Badge Identification of Employees in a Hospital Setting (H606-A/15)	BSAPH	Ad Hoc
H605	Interoperability of Health Information Technology (H607-A/15)	BSA	Ad Hoc
H606	Gifts to Physicians from Industry (H612-A/15)	Ethics	Ad Hoc
H607	Physician Competency Retesting (H614-A/15)	BOS	Ad Hoc
H608	Health Plan Coverage of Tobacco Cessation Treatment (H615-A/15)	BSA	Ad Hoc
H609	Encouraging Patient Participation in Their Health Care (H616-A/15)	BSAPH	Ad Hoc
H610	Frivolous Liability Lawsuits (H617-A/15)	BFHP	Ad Hoc
H611	Provider Tax (H618-A/15)	BSGA	Ad Hoc
H612	Medicaid Payment (H619-A/15)	BSGA	Ad Hoc
H613	Lay Midwives (H620-A/15)	BSGA	Ad Hoc
H614	Medical Malpractice Judgments Requiring Reimbursement of Medicare Payments (H621-A/15)	BSA	Ad Hoc
H615	Electronic Health Records – Physician Assistance Programs for Transition to (H622-A/15)	BSA	Ad Hoc
H616	Prescription Medications -- Overrides for (H624-A/15)	BSGA	Ad Hoc
H617	Pediatric Psychiatric Care Health Records (H625-A/15)	BSA / BSAPH	Ad Hoc
H618	Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder (H626-A/15)	BSA	Ad Hoc
H619	Medicare Recovery Audit Contractors (H628-A/15)	BSA	Ad Hoc

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SPECIAL MEETING OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
AD HOC - RESOLUTION ROSTER
As of September 24, 2020

Res. No.	Resolution Title	Submitted By	Reference Committee
H620	Medicare Law and Rules (H629-A/15)	BFHP	Ad Hoc
H621	Veterans Administration Credentialing of Non-Physician Providers Health Records (H630-A/15)	BFHP	Ad Hoc
H622	Tax Credits for Health Profession Shortage Areas (H631-A/15)	BFHP	Ad Hoc
H623	Osteopathic Manipulative Treatment (OMT) in a Pre-Paid Environment –Payment Policies for (H632-A/15)	BSA	Ad Hoc
H624	Prescription of Drugs for Off Label Uses (H633-A/15)	BFHP	Ad Hoc
H625	Newborn and Infant Hearing Screens (H635-A/15)	BSAPH	Ad Hoc
H626	Medicare Preventive Medical Screening (H636-A/15)	BFHP	Ad Hoc
H627	Confidentiality of Patient Records (H637-A/15)	Ethics	Ad Hoc
H628	Diabetics Confined to Correctional Institutions (H638-A/15)	BSAPH	Ad Hoc
H629	Discrimination by Insurers (H639-A/15)	BSA	Ad Hoc
H630	Executions in Capital Crimes Criminal Cases (H640-A/15)	Ethics	Ad Hoc
H631	Managed Care – All Products Clauses (H642-A/15)	BSGA	Ad Hoc
H632	Medical Procedure Patents (H643-A/15)	BFHP	Ad Hoc
H633	Medicare Contractor Denial Letters (H644-A/15)	BSA	Ad Hoc
H634	Osteopathic Medical Student, Resident, and Physician Mental Health (H646-A/15)	BEL	Ad Hoc
H635	American Osteopathic Association (AOA) Osteopathic Manipulative Treatment (OMT) Coverage Determination Guidance (H647-A/15)	BSA	Ad Hoc
H636	Access to Care – Network Adequacy and Coverage	BSGA	Ad Hoc
H637	Addressing Fears and Barriers to Telemedicine Implementation and Alignment	MOA	Ad Hoc
H638	Addressing Social Determinants of Health Through Data Collection and Improved Access to Social Services	SOMA	Ad Hoc
H639	Elimination of Prior Authorization and Step Therapy	MOA	Ad Hoc
H640	H623-A/18 Non-Physician Clinicians	BSGA	Ad Hoc
H641	Marketing AOA Board Certification	AOCOPM	Ad Hoc
H642	Prior Authorization	BSA	Ad Hoc
H643	Professional Liability Insurance Reform	BSGA	Ad Hoc
H644	Re-Establishment of the Bureau of Osteopathic Specialty Societies (BOSS)	AOCOPM	Ad Hoc

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SPECIAL MEETING OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
AD HOC - RESOLUTION ROSTER
As of September 24, 2020

Res. No.	Resolution Title	Submitted By	Reference Committee
H645	REFERRED RESOLUTION: H636-A/2019 Obesity Treatment Reimbursement in Primary Care	BSA	Ad Hoc
H646	REFERRED RESOLUTION: H-615: Postpartum Depression	BSAPH	Ad Hoc
H647	REFERRED SUNSET RESOLUTION: H-619 - A/2019: H624-A/14 Managed Care Plans – Service, Access and Costs in	BSA	Ad Hoc
H648	Researching Patient Safety and Provider Qualifications	SOMA	Ad Hoc
H649	Support the Bolstering of Veteran Health Administration Resources Through Provider Pay Reform	SOMA	Ad Hoc
H650	Telemedicine; Reimbursement for	NYSOMS	Ad Hoc

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
AD HOC (600 SERIES)

House of Delegates' Reference Committee Description:
Ad Hoc Committee (600 series)
This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-600	Decreasing the Limitations on Prescribing Calcitonin Gene-Related Peptide (CGRP) Inhibitors in Primary Care	OOA	Ad Hoc	REFERRED
H-601	ADVOCATING FOR ~~Requiring the~~ Coverage of Elemental Formula in State, Federal, And Private Insurance Programs	BFHP	Ad Hoc	ADOPTED as AMENDED
H-602	Prior Authorization	CERA	Ad Hoc	ADOPTED
H-603	AOA Policy on Telehealth - H601-A/17	CERA	Ad Hoc	ADOPTED as AMENDED
H-604	Patient Access to Home Health Services	CERA	Ad Hoc	ADOPTED as AMENDED
H-605	Disaster Relief Volunteers (SR-Source: H313-A/16)	CSHA/BFHP	Ad Hoc	ADOPTED as AMENDED
H-606	Electronic Medical/Health Record Exemption Without Penalty (SR-Source: H326-A/16)	CERA	Ad Hoc	ADOPTED
H-607	Physician Administered OMT (SR-Source: H601-A/16)	CERA	Ad Hoc	ADOPTED
H-608	Mandatory Participation in Insurance Plans (SR-Source: H617-A/16)	CERA	Ad Hoc	ADOPTED
H-609	Medicare Claims Coding – Centers for Medicare and Medicaid Services Communications with Physicians (SR-Source: H620-A/16)	CERA	Ad Hoc	ADOPTED
H-610	Physician Negotiation Rights (SR-Source: H622-A/16)	CERA	Ad Hoc	ADOPTED as AMENDED

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101st ANNUAL AOA HOUSE OF DELEGATES MEETING
2021 RESOLUTION ROSTER WITH ACTION
AD HOC (600 SERIES)

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-611	Readmission Rates by the Centers for Medicare and Medicaid Services as a Criterion for Ranking – Opposition to use of (SR-Source: H626-A/16)	CERA	Ad Hoc	ADOPTED
H-612	Current Procedural Terminology (CPT) Codes –Blending Rates (SR-Source: H629-A/16)	CERA	Ad Hoc	ADOPTED as AMENDED
H-613	Health Insurance Exchanges (SR-Source: H633-A/16)	CERA	Ad Hoc	ADOPTED
H-614	Access To Care – Network Adequacy and Coverage (SR-Source: H635-A/16)	CERA/CSHA	Ad Hoc	ADOPTED
H-615	Third Party ~~Payor~~ INSURER Coverage Process Reform (SR-Source: H637-A/16)	CERA	Ad Hoc	ADOPTED as AMENDED
H-616	Merit-Based Incentive Payment System (MIPS) & Alternative Payment Models (APMS) (SR-Source: H638-A/16)	BFHP	Ad Hoc	ADOPTED
H-617	Health Insurer Consolidation (SR-Source: H643-A/16)	CERA/CSHA /BFHP	Ad Hoc	ADOPTED as AMENDED
H-618	Medicare Medical Necessity Certification Requirements (SR-Source: H645-A/16)	BFHP	Ad Hoc	ADOPTED as AMENDED
H-619	Expanding Gender Identity Options on Physician Intake Forms (SR-Source: H647-A/16)	BORPH	Ad Hoc	ADOPTED as AMENDED

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102nd ANNUAL AOA HOUSE OF DELEGATES
JULY 17, 2022, MEETING
RESOLUTION ROSTER (600 SERIES)

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTIONS:
Ad Hoc Committee (600 series)
This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-600	Osteopathic Neurologic and Psychiatric Standard of Care (SR- Source: H604-A/17)	BORPH/ CSHA	Ad Hoc	Adopted
H-601	Physician / Patient Educational Materials Received from Pharmaceutical Companies that Produce and/or Market Generic Medications (SR - Source: H615-A/17)	BORPH	Ad Hoc	Adopted
H-602	Osteopathic Musculoskeletal Evaluation (SR- Source: H623-A/17)	BORPH	Ad Hoc	Adopted as Amended
H-603	Adjustment to Primary Care Incentive Program (SR - Source: H602-A/17)	BFHP	Ad Hoc	Adopted as Amended
H-604	Physician Depositions (SR - Source: H605-A/17)	CSHA	Ad Hoc	Adopted
H-605	The Practice of Osteopathic Medicine Discrimination (SR - Source: H608-A/17)	CSHA	Ad Hoc	Adopted
H-606	Drug Prescribing, Including Elderly Patients (SR - Source: H609-A/17)	CSHA	Ad Hoc	Adopted as Amended
H-607	Human Immunodeficiency Virus (HIV) – Positive Status as a Disability for Physicians (SR - Source: H610-A/17)	CSHA	Ad Hoc	Adopted
H-608	Health Care Fraud and Abuse (SR - Source: H611-A/17)	CSHA	Ad Hoc	Adopted
H-609	Military Medical Readiness (SR- Source: H613-A/17)	BFHP	Ad Hoc	Adopted
H-610	Payment For Psychiatric Diagnoses and Treatment by Primary Care Physicians (SR- Source: H618-A/17)	CSHA	Ad Hoc	Adopted
H-611	Physician Fines Imposed by Third Party Payors (SR- Source: H621-A/17)	BFHP	Ad Hoc	Adopted
H-612	Health Care Insurance Options (SR - Source: H622-A/17)	CSHA	Ad Hoc	Adopted
H-613	Physician Payment in Federal Programs (SR - Source: H624-A/17)	BFHP	Ad Hoc	Adopted as Amended
H-614	Human Immunodeficiency Virus (HIV) Consent Form Elimination	BFHP	Ad Hoc	Adopted

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102nd ANNUAL AOA HOUSE OF DELEGATES
JULY 17, 2022, MEETING
RESOLUTION ROSTER (600 SERIES)

	(SR - Source: H625-A/17)			
H-615	Direct Primary Care (SR- Source: H628-A/17)	BFHP	Ad Hoc	Adopted as Amended
H-616	Opposition to the Practice of LGBTQIA+ Conversion Therapy or Reparative Therapy (SR- Source: H629-A/17)	CSHA	Ad Hoc	Adopted as Amended
H-617	Standing Against Sexual Orientation Change Efforts (SOCE) (SR- Source: H635-A/17)	BFHP	Ad Hoc	Adopted for Sunset
H-618	Patient Interpreters (SR - Source: H636-A/17)	BFHP	Ad Hoc	Adopted
H-619	AOA Opposition to Merging of State Osteopathic Licensing Boards with State Medical Licensing Boards (SR - Source: H637-A/17)	CSHA	Ad Hoc	Adopted as Amended
H-620	Prescription Drug Pricing (SR - Source: H638-A/17)	CSHA	Ad Hoc	Adopted as Amended
H-621	WITHDRAWN BY AUTHOR			
H-622	Addressing Insurance Denials	MAOPS	Ad Hoc	Referred
H-623	WITHDRAWN BY AUTHOR			
H-624	Reducing the Waiting Period for Credentialing, Re-Credentialing and Enrollment of Health Care Professionals by Health Plans	MOA	Ad Hoc	Adopted as Amended
H-625	Expanding Seven Core Competencies to Include Diverse Patient Populations Including but not limited to LGBTQ+ within Standardized Patient Education	OPSC	Ad Hoc	Referred
H-626	Expanding Scheduled Dialysis Services to all Patients with End Stage Kidney Disease	SOMA	Ad Hoc	Disapproved

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103rd ANNUAL AOA HOUSE OF DELEGATES MEETING
2023 RESOLUTION ROSTER (600 SERIES) -w/ACTION
As of 07-24-23

HOUSE OF DELEGATES' REFERENCE COMMITTEE DESCRIPTIONS:
Ad Hoc Committee (600 series)
This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-600	Centers For Medicare and Medicaid Services Policies (SR–Source:H600-A/18)	BFHP	Ad Hoc	Adopted
H-601	Combating Pharmaceutical Evergreening to Decrease Healthcare Costs and Increase Quality, Competition (SR–Source:H629-A/18)	BFHP	Ad Hoc	Adopted as Amended
H-602	Comprehensive Gun Violence Reform (SR–Source:H630-A/18)	BFHP	Ad Hoc	Adopted
H-603	Increasing the Education and **AVAILABILITY** ~~Preventative Prescribing~~ of Naloxone Use for Opioid Overdose (SR–Source:H632-A/18)	BFHP	Ad Hoc	Adopted as Amended
H-604	Recognizing Sexual Assault Survivors -Rights (SR–Source:H634-A/18)	BFHP	Ad Hoc	Adopted
H-605	Urge Congress to Retain DACA Protections (SR–Source:H637-A/18)	BFHP	Ad Hoc	Adopted as Amended
H-606	Veterans – Health Care for U.S. (SR–Source:H614-A/18)	BFHP	Ad Hoc	Adopted as Amended
H-607	AOA Accreditation of Sponsors Providing Osteopathic Continuing Medical Education (AOA Category 1-A) (SR-Source:H618-A/18)	BOE	Ad Hoc	Adopted
H-608	Tenets of Osteopathic Medicine (SR-Source:H617-A/18)	BOE	Ad Hoc	Adopted
H-609	Taser Safety (SR-Source:H615-A/18)	BORPH	Ad Hoc	Referred to BORPH
H-610	Tobacco Use in Entertainment Media (SR-Source:H613-A/18)	BORPH	Ad Hoc	Adopted
H-611	Cancer Screening- Payment for (SR-Source:H603-A/18)	CERA	Ad Hoc	Adopted
H-612	Qualifications for the Practice of OMT and the Coding and Billing for (SR-Source:H608-A/18)	CERA	Ad Hoc	Adopted as Amended

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2023 RESOLUTION ROSTER (600 SERIES) -w/ACTION
As of 07-24-23

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-613	ICD-10 Codes for Laboratory Tests-Assignment of Appropriate (SR-Source:H610-A/18)	CERA	Ad Hoc	Adopted
H-614	Opposing Policies by Third Party Payors that may Negatively Impact the Provision of Healthcare (SR-Source:H607-A/18)	CERA	Ad Hoc	Adopted as Amended
H-615	Physician Co-Management of a Patient (SR-Source:H604-A/18)	CERA	Ad Hoc	Adopted as Amended
H-616	Recovery Audit Contractors (RAC)- Payment of (SR-Source:H606-A/18)	CERA	Ad Hoc	Adopted
H-617	Criminal Liability for Clinical Decisions (SR-Source:H605-A/18)	CSHA	Ad Hoc	Adopted as Amended
H-618	Osteopathic Graduate Medical Education (SR-Source:H611-A/18)	BOE	Ad Hoc	Adopted as Amended
H-619	Board Certification of Insurance Company Peer Reviewers	MAOPS	Ad Hoc	Adopted as Amended
H-620	Licensure of Insurance Company Employed Physicians	MAOPS	Ad Hoc	Adopted as Amended
H-621	Reducing Burdens in the Utilization of Step Therapy	MOA	Ad Hoc	Not Adopted
H-622	Protection of the Patient-Physician Relationship and Opposition to Physician Penalties for the Provision of Gender Affirming Care	OOA	Ad Hoc	Adopted as Amended
H-623	Invisible Disabilities	OOA	Ad Hoc	Adopted as Amended
H-624	Improving Pharmaceutical Formulary Accessibility	OOA	Ad Hoc	Adopted as Amended
H-625	Conflicts Between Employed Physicians and Employers	IOMA	Ad Hoc	Referred to IOMA
H-626	Non-Physician Clinician Medical Liability	IOMA	Ad Hoc	Adopted as Amended
H-627	CAQ for Bariatric Surgery	ACOS	Ad Hoc	Not Adopted

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As of 07-24-23

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-628	In Support of Training and Advocacy for Diverse Patient Populations Including but Not Limited to LGBTQ2+ Within Residency	OPSC	Ad Hoc	Adopted as Amended
H-629	Minimal Credentialing in Post-Acute and Long-Term Care (PALTC) Medicine	FOMA	Ad Hoc	Adopted as Amended
H-630	Requirement for Minimum Education Standards for Medical Directors	FOMA	Ad Hoc	Adopted as Amended
H-631	Implementing Land Acknowledgements at American Osteopathic Association (AOA) Events	SOMA	Ad Hoc	Referred to SOMA
H-632	Increasing Access to Affordable Insurance for Undocumented Immigrants	SOMA	Ad Hoc	Not Adopted
H-633	Non-Compete Clauses in Healthcare Employment Contracts	BFHP	Ad Hoc	Adopted as Amended

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104th ANNUAL AOA HOUSE OF DELEGATES MEETING
2024 RESOLUTION ROSTER (600 SERIES) W/ACTION
As of 07-22-24

HOUSE OF DELEGATES REFERENCE COMMITTEE DESCRIPTIONS:
Ad Hoc Committee (600 series)
This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-600	Cooperation of the Veterans Administration and Non-VA Clinicians (SR-Source-H634-A/19)	BFHP	Ad Hoc	Adopted
H-601	Addressing the Gender Pay Gap in the Medical Profession (SR-Source-H638-A/19)	BFHP	Ad Hoc	Adopted
H-602	Investment Tax (SR-Source-H610-A/19)	BFHP	Ad Hoc	Adopted
H-603	Family Medical Leave Act Employee Relationship Modification (SR-Source-H603-A/19)	BFHP	Ad Hoc	Adopted
H-604	Industry Transparency Standards (SR-Source-H622-A/19)	BFHP	Ad Hoc	Adopted as Amended
H-605	OMT – Osteopathic Manipulative Treatment (SR-Source-H611-A/19)	BORPH	Ad Hoc	Adopted
H-606	Drug Therapy Surveyor Guidelines for Nursing Homes (SR-Source-H607-A/19)	BORPH	Ad Hoc	Adopted
H-607	Beer's Criteria for Potentially Inappropriate Medication Use in Older Adults - Use Of (SR-Source-H625-A/19)	BORPH	Ad Hoc	Adopted
H-608	Latex Allergy (SR-Source-H618-A/19)	BORPH	Ad Hoc	Adopted
H-609	Pharmaceutical Packaging/ Environmental Responsibility (SR-Source-H621-A/19)	BORPH	Ad Hoc	Adopted
H-610	Standing Against Restrictive Housing and Solitary Confinement for Juvenile Inmates of Prison Systems in the U.S. (SR-Source-H628-A/19)	BORPH	Ad Hoc	Adopted as Amended
H-611	Third-Party Payers and Utilization Review Firms – Accountability (SR-Source-H612-A/19)	CERA	Ad Hoc	Adopted as Amended
H-612	Local Coverage Determination (SR-Source-H617-A/19)	CERA	Ad Hoc	Adopted
H-613	Mergers and Buy-Outs of Third-Party Payers (SR-Source-H615-A/19)	CERA	Ad Hoc	Adopted

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As of 07-22-24

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-614	Federal Health Information Technology Incentives – AOA Support (SR-Source-H616-A/19)	CERA	Ad Hoc	Adopted as Amended
H-615	Electronic Health Records Software – Reporting Errors to Physicians (SR-Source-H623-A/19)	CERA	Ad Hoc	Adopted as Amended
H-616	Government Intervention in Private Practice (SR-Source-H606-A/19)	CERA	Ad Hoc	Adopted
H-617	Patient Matching of Electronic Health Record Data (SR-Source-H632-A/19)	CERA	Ad Hoc	Adopted as Amended
H-618	Centers For Medicare and Medicaid Communications with Physicians (SR-Source-H608-A/19)	CERA	Ad Hoc	Adopted
H-619	Mandated Patient Care – Assignment of (SR-Source-H609-A/19)	CERA	Ad Hoc	Adopted as Amended
H-620	Hospice – Federal Reimbursement for Required Face-to-Face Visits (SR-Source-H600-A/19)	CERA	Ad Hoc	Adopted
H-621	Palliative Care – Federal Funding for Support Services (SR-Source-H601-A/19)	CERA	Ad Hoc	Adopted
H-622	Regulation of Health Information Technology Software (SR-Source-H603-A/19)	CERA	Ad Hoc	Adopted as Amended
H-623	Emerging States – Assistance by Other States and the AOA (SR-Source-H604-A/19)	CSHA	Ad Hoc	Adopted as Amended
H-624	Mail Order Pharmacy (SR-Source-H613-A/19)	CSHA	Ad Hoc	Adopted
H-625	Maintenance of Licensure (SR-Source-H627-A/19)	CSHA	Ad Hoc	Adopted
H-626	Osteopathic Terminology - Glossary of (SR-Source-H605-A/19)	BOM	Ad Hoc	Adopted as Amended
H-627	Taser Safety – Referred Sunset Resolution H609-A/23 (SR-Source-H615-A/18)	BORPH	Ad Hoc	Adopted as Amended
H-628	Physician Payment Adjustments for Budget Neutrality	FOMA (Florida)	Ad Hoc	Adopted as Amended
H-629	House of Delegates Committees	FOMA (Florida)	Ad Hoc	Not Adopted

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2024 RESOLUTION ROSTER (600 SERIES) W/ACTION
As of 07-22-24

Res. No.	Resolution Title	Submitted By	Reference Committee	Action
H-630	Preventing the Criminalization of Medical Decision Making	MOA (Maine)	Ad Hoc	Referred to Maine
H-631	Approved Resolutions Status	OPSC (California)	Ad Hoc	Adopted as Amended
H-632	Appeal CMS Physician Payment Rule for Medicare	OPSC (California)		Withdrawn
H-633	OMT Coverage Determination Guidance - Amendment to Policy H635-A/20	BFHP	Ad Hoc	Referred to BFHP
H-634	Prior Authorization Requirement for Reimbursement for Osteopathic Manipulative Treatment	AAO	Ad Hoc	Adopted as Amended

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Dissemination of Publications in Osteopathic Research

Policy Statement

The American Osteopathic Association (AOA) will widely disseminate publications, research, and evidence based medicine regarding Osteopathic Medicine and Osteopathic Manipulative Treatment (OMT) and its anatomical and physiological basis to the greater public via prominent, designated public information sites, social networking, public information releases, websites, and other media.

Source: H600-A/20

Status: 2015; 2020 Reaffirmed

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Proper Badge Identification of Employees in a Hospital Setting

Policy Statement

The American Osteopathic Association (AOA) encourages all healthcare providers and hospital employees to wear hospital-issued identification badges with clear delineation of their professional role and that they verbally introduce and identify themselves and their role in the patient's treatment process, with the overall goal of improving patient safety and patient communication.

Source: H604-A/20

Status: 2015; 2020 Reaffirmed

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Interoperability of Health Information Technology

Policy Statement

The American Osteopathic Association (AOA) supports a new risk-based oversight framework for clinical software, developed through a multi-stakeholder consensus-based process. the framework should take into account risk relative to intended use, cost/benefit of proposed oversight, and the principle of shared responsibility. patient safety and appropriate improvements in quality, effectiveness, and efficiency of care delivery should be paramount. this framework should not conflict with or duplicate the medical device regulation framework. the AOA does not support data be treated as a medical device, regardless of the category of health it associated with the data. the AOA supports a national network for reporting patient safety events and other information vital to public health, where data can be accessed, analyzed, and communicated in a timely manner. The regulatory framework should promote interoperability, in order for clinical information systems to capture and share quality, outcome, cost, and patient healthcare data. To support coordinated health care and data analytics to promote transition to a value-based healthcare system. the AOA supports a common data structure that will enable interoperability, setting a clear course of action, federal support for an exchange infrastructure, and standards which will make it easier to share information so physicians and patients can make informed decisions.

The AOA will encourage public and private sector stakeholders to develop clinically driven, standardized products that are interoperable by design, do not require costly and time-consuming customization, and for which any upgrades or future needs can be integrated seamlessly without burdensome costs or system modifications. The AOA also supports standardization of prior authorization attachments to alleviate burden and reduce delays to care.

The AOA opposes vendors blocking health care professionals' ability to access, view, share, or transfer data.
The AOA supports policies and technologies that facilitate person-centered health care.

The AOA will remain vigilant about mitigating the level of administrative burden posed by existing and new government policies.

Source: H605-A/20

Status: 2015; 2020 Reaffirmed

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Gifts to Physicians from Industry

Policy Statement

The American Osteopathic Association (AOA) has adopted the following "Guide to Section 17 of the AOA Code of Ethics" as follows and will distribute this information to students of osteopathic medicine and osteopathic physicians.

1. Physicians' responsibility is to provide appropriate care to patients. This includes determining the best pharmaceuticals to treat their condition. This requires that physicians educate themselves as to the available alternatives and their appropriateness so they can determine the most appropriate treatment for an individual patient. Appropriate sources of information may include journal articles, continuing medical education programs, and interactions with pharmaceutical representatives.

2. It is ethical, for osteopathic physicians to meet with pharmaceutical companies and their representatives for the purpose of product education, such as, side effects, clinical effectiveness and ongoing pharmaceutical research.

3. Pharmaceutical companies may offer gifts to physicians from time to time. These gifts should be appropriate to patient care or the practice of medicine. Gifts unrelated to patient care are generally inappropriate. The use of a product or service based solely on the receipt of a gift shall be deemed unethical.

4. When a physician provides services to a pharmaceutical company, it is appropriate to receive compensation. However, it is important that compensation be in proportion to the services rendered. Compensation should not have the appearance of a relationship to the physician's use of the company's products in patient care.

Source: H606-A/20

Status: 1991, 1994 Revised, 1999, 2003; 2008; 2015 Reaffirmed as Amended; 2020 Reaffirmed

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Physician Competency Retesting

Policy Statement

The American Osteopathic Association (AOA):

(1) Supports the mission of physician competency, the quality movement and patient safety through self-regulation mechanisms rather than through government mandated retesting for purposes of obtaining re-licensure or for receiving payment under a health benefits program.

(2) Continue its voluntary efforts to address and promote physician competency through the teaching of core competencies at the predoctoral and postdoctoral levels, physician assessment through osteopathic continuous certification.

Source: H607-A/20

Status: 1991, 1994 Revised, 1999, 2003; 2008; 2015 Reaffirmed as Amended; 2020 Reaffirmed

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Health Plan Coverage of Tobacco Cessation Treatment

Policy Statement

The American Osteopathic Association (AOA) encourages all health plans to follow tobacco cessation recommendations of the Centers for Disease Control and Prevention (CDC) and encourages all health care plans to accept CPT, and ICD-10 codes for tobacco use as legitimate codes for payment for services provided for these codes.

Source: H608-A/20

Status: 2010; 2015 Reaffirmed as Amended; 2020 Reaffirmed

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Provider Tax

Policy Statement

The American Osteopathic Association (AOA) opposes any effort by a state or the federal government to impose a provider tax of any type.

Source: H611-A/20

Status: 2010; 2015 Reaffirmed; 2020 Reaffirmed

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Medicaid Payment

Policy Statement

The American Osteopathic Association (AOA) supports the efforts in each state to uphold their obligation to pay physicians and hospitals at a fair and equitable rate for providing quality care to the state's Medicaid recipients

Source: H612-A/20

Status: 2010; 2015 Reaffirmed as Amended; 2020 Reaffirmed as Amended

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Lay Midwives

Policy Statement

The American Osteopathic Association (AOA) opposes the licensing of lay midwives and will continue providing support to affiliate societies in opposing state's efforts to license lay midwives.

Source: H613-A/20

Status: 2010; 2015 Reaffirmed; 2020 Reaffirmed

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Electronic Health Records – Physician Assistance Programs for Transition to

Policy Statement

The American Osteopathic Association (AOA) will continue to support solo practice physicians and small-group practices in the adoption of health information technology (HIT). The AOA supports incentives or enhanced payments for adoption of innovative hit that improves care delivery, coordination, and value.

Source: H615-A/20

Status: 2005; 2010 Revised; 2015 Reaffirmed as Amended; 2020 Reaffirmed as Amended

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Pediatric Psychiatric Care Health Records

Policy Statement

The American Osteopathic Association supports the development of educational programs to assist primary care physicians to identify and initiate appropriate support of pediatric psychiatric care and encourages insurance providers to adequately reimburse counseling and psychiatric care deemed necessary by the patient's primary care physician.

Source: H617-A/20

Status: 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

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Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder

Policy Statement

The American Osteopathic Association (AOA) urges insurance carriers to provide coverage for attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) patients by primary care physicians.

Source: H618-A/20

Status: 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

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Veterans Administration Credentialing of Non-Physician Providers Health Records

Policy Statement

The American Osteopathic Association (AOA) supports the establishment of well-defined credentialing and privileging criteria within the Veterans Administration (VA) that prohibits non-physician providers with expanded scope of practice rights in a minority of states from demanding such privileges in the VA system and supports the establishment of a consistent requirement for the privileging of non-physician providers in the VA system.

Source: H621-A/20

Status: 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

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Tax Credits for Health Profession Shortage Areas

Policy Statement

The American Osteopathic Association (AOA) supports the establishment of tax credits for physicians who practice full time in federally designated health professions shortage areas (HPSAs) or Medicare defined physician scarcity areas and federally and/or state designated underserved areas and urges that these tax credits be available, on a sliding scale, to physicians who provide services on a part-time basis in these communities.

Source: H622-A/20

Status: 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

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Prescription of Drugs for Off Label Uses

Policy Statement

The American Osteopathic Association (AOA) believes it is appropriate for physicians to prescribe approved drugs for uses not included in their official labeling when they can be supported as accepted medical practice.

Source: H624-A/20

Status: 1995; 2000 Reaffirmed; 2005; 2010; 2015; 2020 Reaffirmed

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Newborn and Infant Hearing Screens

Policy Statement

The American Osteopathic Association (AOA) supports adequate funding for universal hearing screening and intervention for newborns and infants.

Source: H625-A/20

Status: 1995; 2000 Revised, 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

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Medicare Preventive Medical Screening

Policy Statement

The American Osteopathic Association (AOA) supports coverage of Medicare recipients for routine preventive medical services.

Source: H626-A/20

Status: 1995; 2000 Reaffirmed, 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

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Confidentiality of Patient Records

Policy Statement

The American Osteopathic Association (AOA) opposes invasion of privacy of the patient record by any unauthorized person or agency; and endorses reasonable programs which seek to protect patient/physician relationships and guarantee confidentiality of patient records.

Source: H627-A/20

Status: 1980; 1985 Revised,1990,1995; 2000, 2005; 2010 Reaffirmed; 2015; 2020 Reaffirmed

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Diabetics Confined to Correctional Institutions

Policy Statement

The American Osteopathic Association supports the availability of American Diabetes Association (ADA) diabetic meals, beverages, and other diabetic interventions that follow ADA guidelines for all imprisoned persons with diabetes, who are under the care of a licensed physician, and confined in correctional institutions.

Source: H628-A/20

Status: 2000, 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

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Executions in Capital Crimes Criminal Cases

Policy Statement

The American Osteopathic Association deems it an unethical act for any osteopathic physician to deliver or be required to deliver a lethal injection for the purpose of execution in capital crimes.

Source: H630-A/20

Status: 1995; 2000 Revised; 2005 Reaffirmed; 2010; 2015 Referred; 2020 Reaffirmed

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Managed Care – All Products Clauses

Policy Statement

The American Osteopathic Association and state osteopathic societies oppose the use of “all products/all products developed in the future” clauses in physician managed care contracts; actively opposes the use of any other clauses that may limit the ability of the physician to choose the plans in which he or she participates; and supports both state and federal legislation as well as regulatory agency regulations and rulings to prohibit the use of “all products/all products developed in the future” clauses in physician managed care contracts.

Source: H631-A/20

Status: 2000; 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

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Medical Procedure Patents

Policy Statement

The American Osteopathic Association (AOA) supports measures that restrict medical procedure patents.

Source: H632-A/20

Status: 1995; 2000 Reaffirmed, 2005 Revised; 2010 Reaffirmed; 2015; 2020 Reaffirmed

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Osteopathic Manipulative Treatment (OMT) Coverage Determination Guidance

Policy Statement

The American Osteopathic Association (AOA) approves the attached policy as the standard guidelines for OMT coverage and encourages all public and private payers to refer to the AOA's policy when developing new policy or revising existing guidance for OMT coverage.

American Osteopathic Association (AOA) Policy on Osteopathic Manipulative Treatment (OMT)

Introduction to OMT

Osteopathic manipulative treatment (OMT) is a distinct medical procedure used by physicians (DOs/MDs) to treat somatic dysfunction or other conditions. The American Association of Colleges of Osteopathic Medicine (AACOM) Glossary of Osteopathic Terminology defines OMT as the therapeutic application of manually guided forces by a physician to improve physiologic function and/or support homeostasis that has been altered by somatic dysfunction. Somatic dysfunction in one region may lead to compensatory somatic dysfunction in other regions. The AACOM Glossary of Osteopathic Terminology defines somatic dysfunction as:

> Impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial and myofascial structures, and their related vascular, lymphatic, and neural elements. Somatic dysfunction is treatable using osteopathic manipulative treatment. The positional and motion aspects of somatic dysfunction are best described using at least one of three parameters: 1). The position of a body part as determined by palpation and referenced to its adjacent defined structure, 2). The directions in which motion is freer, and 3). The directions in which motion is restricted.[1]

Osteopathic manipulative treatment can also be used to treat the somatic component of visceral disease and any organ system, which has the potential to manifest as changes in the skeletal, arthrodial and myofascial tissues. (Example: tight right shoulder muscles in a patient with gallbladder disease). Normalizing musculoskeletal activity (relaxing tense muscles, etc.) can normalize outflows through sympathetic or parasympathetic autonomic nervous systems to visceral systems, resulting in more normal visceral and any organ system function.
Somatic dysfunction is identified on the physical exam by one or more elements of TART (**T**issue texture changes, positional **A**symmetry, **R**ange of motion alterations, or changes in palpatory sensitivity, e.g., **T**enderness).

Provider Types Qualified to Perform OMT

To perform OMT a qualified Doctor of Osteopathic Medicine must have graduated from an accredited school of osteopathic medicine or a medical doctor must have completed a board-approved postgraduate osteopathic training program that encompasses osteopathic principles and practices, including hands-on demonstration and competency testing in OMT.

OMT Payment:

[1] The American Association of Colleges of Osteopathic Medicine (AACOM) Glossary of Osteopathic Terminology, November 2011.

The decision to utilize osteopathic manipulative treatment (OMT) as part of the overall health care of patients is made on a visit-by-visit basis. As such, it is typical to perform a history and physical examination on initial and subsequent encounters. Based on the history and findings of the physical examination, the physician may decide to use OMT as part of the overall care of the patient. OMT is a paid service when somatic dysfunction is documented in the history and/or the physical examination. OMT is not paid when somatic dysfunction is absent from the patient's history or physical examination documentation. The method of OMT employed by the physician is determined by the patient's condition, age and the effectiveness of previous methods of treatment.

OMT Documentation

The medical record documentation should include a history and physical. If an E/M service is being reported on the same day as OMT, the documentation should clearly distinguish the services that constitute the E/M service and the OMT service. The documentation should clearly identify the body regions affected and treated with OMT in order to support the procedure code(s)reported.

The selection of body region(s) to which OMT is applied should reflect the region(s)of documented somatic dysfunction. There may be instances when multiple regions are treated due to the occurrence of compensatory changes. When this occurs, the documentation should describe the compensatory changes and the rationale for treating this area, especially if the patient has no complaints related to this area. Treatment should be directed to the areas of documented somatic dysfunction and should not be aimed at areas unrelated to the diagnosis. The type, frequency and duration of OMT should be consistent with current standards of medical practice.

Factors that may affect frequency and duration of treatment are: severity of illness, duration or chronicity of the patient's condition and the presence of co-morbidities. These factors should be reflected in the medical record if they contribute to the physician's treatment approach.

The American Osteopathic Association strongly recommends that documentation include a procedure note to detail the regions manipulated, the techniques utilized, and a description of how the patient tolerated the treatment.

OMT Vignettes and Coding Examples

In April 2010, the American Medical Association (AMA) Relative Value Update Committee (RUC) requested that the AOA survey the existing OMT codes to develop accurate and unbiased information for the relative value of the physician work involved in performing OMT as part of the Centers for Medicaid and Medicare Services (CMS) forth fifth year review of RBRVS. The survey process required the creation of vignettes to describe the typical patient for OMT CPT® Codes 98925-98929. Additionally, the description of the preservice, intraservice, and postservice work for OMT was included. As of January 2012, the vignettes for the typical patient and the preservice, intraservice and postservice descriptors are contained within the RUC database.

There are five OMT Service Current Procedural Terminology (CPT©) Codes (98925-98929). Below find the vignettes, description for the preservice, intraservice and postservice work and coding examples for the OMT codes 98925-98929.

Note: The OMT service codes do not include any elements of the history, examination and medical decision making.

OMT service code 98925: Osteopathic manipulative treatment (OMT); to one to two body regions defined**.**

Vignette:

A 25-year-old female presents with right lower neck pain of two weeks duration. Somatic dysfunction of cervical and thoracic regions are identified on exam.

Description of Preservice Work:

The physician determines which osteopathic techniques (eg, HVLA, muscle energy, counterstrain, articulatory, etc) would be most appropriate for this patient, in what order the affected body regions need to be treated and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.

Description of Intraservice Work:

Patient is initially in the supine position on the treatment table. Motion restrictions of C6 and C7 are isolated through palpation and treated using muscle energy technique. Dysfunctions of T1 and T2 are treated using passive thrust (HVLA) technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.

Description of Postservice Work:

Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.

OMT Service code 98926: Osteopathic manipulative treatment (OMT); 3-4 body regions involved

Vignette:

A 39-year-old female presents with right lower back pain of two weeks duration after a lifting injury. Somatic dysfunction of lumbar, pelvis and sacral regions are identified on exam.

Description of Pre-Service Work:

The physician determines which osteopathic techniques (eg, HVLA, Muscle energy, Counterstrain, articulatory, etc., for a complete list of techniques see the American Association of Colleges of Osteopathic Medicine Glossary of Osteopathic Terminology) would be most appropriate for this patient, in what order the affected body regions need to be treated and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.

Description of Intra-Service Work:

The patient is initially in the prone position on the treatment table. Motion restrictions of sacrum and pelvis are isolated through palpation and treated using muscle energy and articulatory techniques. Dysfunctions of L1 and L5 are treated using passive thrust (HVLA) technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.

Description of Post-Service Work:

Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.

OMT service code 98927: Osteopathic manipulative treatment (OMT); five to six body regions defined.
Vignette:
A 17-year-old male presents with pain in the neck, upper and lower back, right shoulder, and right chest following an injury in a high school football game two days ago. Somatic dysfunctions of the right glenohumeral and acromioclavicular joints, as well as the lower cervical, upper thoracic, right upper costal and lumbar areas are identified on exam.
Description of Preservice Work:
The physician determines which osteopathic techniques (eg, HVLA, muscle energy, counterstrain, articulatory, etc) would be most appropriate for this patient, in what order the affected body regions need to be treated and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.
Description of Intraservice Work:
The patient is initially in a side-lying position on the treatment table. Motion restrictions of identified joints are isolated through palpation and treated using a variety of techniques as follows: acromioclavicular joint is treated with articulatory technique; glenohumeral and costal dysfunctions are treated with muscle energy technique; cervical spine is treated with counterstrain technique; thoracic and lumbar dysfunctions are treated with passive thrust (HVLA) technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.
Description of Postservice Work:
Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.
OMT service code 98928: Osteopathic manipulative treatment (OMT); seven to eight body regions defined.
Vignette:
A 64-year-old female, in rehabilitation following a left total knee replacement, presents with swelling in the left lower leg, pain in her low back, hips and pelvis with muscle spasms and numbness and bilateral wrist pain with use of a walker. She has a history of widespread degenerative joint disease with stiffness and pain making it difficult for her to actively participate in her rehabilitation program. Somatic dysfunctions of the lumbar, thoracic and cervical spine, sacrum, pelvis, right leg, and bilateral wrist joints are identified on exam.
Description of Preservice Work:
The physician determines which osteopathic techniques (eg, HVLA, muscle energy, counterstrain, articulatory, etc) would be most appropriate for this patient, in what order the affected body regions need to be treated and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.
Description of Intraservice Work:
The patient is initially in the supine position on the treatment table. Motion restrictions of identified joints are isolated through palpation and treated using a variety of techniques as follows: radiocarpal joints are treated using articulatory and myofascial release techniques; dysfunctions of L3, L5 and SI joints are treated using balanced ligamentous

tension technique; dysfunction of C5 through T3, the pelvis and lower extremity are treated with muscle energy technique. Lower extremity edema is treated with lymphatic drainage techniques. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide further technique application as appropriate.
Description of Postservice Work:
Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.

OMT service code 98929: Osteopathic manipulative treatment (OMT); nine to ten body regions defined.
Vignette:
A 40-year-old male presents with sub-occipital headache, and pain in the neck, upper and lower back, left shoulder and chest, and right ankle. He was involved in a rear-end MVA two weeks ago. X-rays in the ED were negative. He has been taking prescribed analgesic and muscle relaxant medications with minimal improvement. On examination, somatic dysfunction is identified at the occipitoatlantal, left glenohumeral and right tibiotalar joints, as well as the cervical, thoracic, costal, lumbar, sacral and pelvic regions.
Description of Preservice Work:
The physician determines which osteopathic techniques (eg, HVLA, muscle energy, counterstrain, articulatory, etc) would be most appropriate for this patient, in what order the affected body regions need to be treated and whether those body regions should be treated with specific segmental or general technique approaches. The physician explains the intended procedure to the patient, answers any preliminary questions, and obtains verbal consent for the OMT. The patient is placed in the appropriate position on the treatment table for the initial technique and region(s) to be treated.
Description of Intraservice Work:
Patient is initially in the supine position on the treatment table. Motion restrictions of identified joints are isolated through palpation and treated using a variety of techniques as follows: occiptoatlantal joint and sacrum are treated using muscle energy and counterstrain techniques; right glenohumeral joint and pelvis are treated with articulatory technique; lumbar, thoracic, cervical and right ankle are treated with passive thrust (HVLA) technique; costal dysfunctions are treated using muscle energy technique. Patient position is changed as necessary for treatment of the individual somatic dysfunctions. Patient feedback and palpatory changes guide selection of further technique application as appropriate.
Description of Postservice Work:
Post-care instructions related to the procedure are given, including side effects, treatment reactions, self-care, and follow-up. The procedure is documented in the medical record.

Documenting the Patient Visit: S.O.A.P. Note Example[i2]:

Below is an example of a new and established patient encounter and a subjective, objective, assessment and plan (S.O.A.P) note for each to illustrate how to document the patient's visit in the medical record. Other styles and preferences exist for medical record documentation.

[2] American Osteopathic Association Osteopathic Manipulative Treatment Coding Instructional Manual Second Edition, August 2012.

Soap Note – New Patient Example

S. A 20-year-old African-American male complains of low back pain that began three days ago after he lifted a heavy object. Cannot straighten up when walking, pain with change of position. The patient denies radiation of pain and areas of numbness, the pain stays along the back and waist. He is comfortable when lying down, aspirin helps some, has used heat with some help. No prior history of back pain or injury. Denies allergies, medical/surgical history is unremarkable.

O. Tenderness noted over lumbar and sacral regions Inability to extend lumbar spine when standing Flexion posture when standing Muscle spasms noted in paraspinals of the lumbar region Decreased range of motion of lumbar spine and sacrum was noted on active and passive motion testing Neurologic exam normal.

A. 1. Lumbosacral sprain/strain 846.0/533.8XXA
2. Somatic dysfunction lumbar, sacral 739.3/M00.03 739.4/M99.04

P. 1. OMT (appropriate techniques used) applied to the lumbar and sacral regions
2. Continue aspirin
3. No lifting, bending or twisting
4. Follow up in two days to reevaluate patient progress

CODING FOR THIS CASE

Evaluation and Management: new patient 99203
OMT two body regions: lumbar/sacral 98925

Soap Note-Established Patient Example

S: Patient presents to the office for a reevaluation of lower back pain. He states that the pain has decreased in his low back and that he can get around better. He states that he has no radiation of pain in his legs. He does state that he feels stiff and achy if he tries to do his normal daily activities. He is s till taking aspirin with some relief. Denies GI symptoms from aspirin use.

O. Tenderness with palpation and stretch of the erector spinae muscles
Pain with extension and rotation left of L5
Pain along right SI joint with sacral extension
Motion restrictions of lower lumbar vertebrae and sacrum identified
No muscle spasms noted with active or passive range of motion
Negative neurological exam of lower extremities

A. 1. Lumbosacral sprain/strain 846.0/533.8XXA
2. Somatic dysfunction lumbar, sacral 739.3/M99.03
739.4/M99.04

P. 1. OMT (appropriate techniques used) applied to the lumbar and sacral regions
2. Instructed on proper posture when lifting
3. Increased home activities gradually and to tolerance
4. Follow up if improvement does not continue

CODING FOR THIS CASE

Evaluation and Management: established 99213
OMT two body regions: lumbar/sacral 98925

Reporting E/M Services:

Patients present to the office on the initial or a subsequent encounter to address complaints of pain, strains or other signs or symptoms or to address unresolved issues. As such, an E/M service is provided on the initial and subsequent encounter. Patients do not present to the office for OMT.

The E/M service is a separate service from the OMT service, both are separately reportable and payable. Make sure to document the three key components (history, examination and medical

decision making). If utilizing an electronic health record (EHR), ensure that it is capable of capturing all of the history, physical examination and medical decision making and any other service(s) provided on each patient visit.

Per CPT © guidance Evaluation and Management services may be reported separately using Modifier- 25 if the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and postservice work associated with the (OMT) procedure. The E/M service may be caused or prompted by the same symptoms or condition for which the OMT service was provided. As such, different diagnoses are not required for reporting of the OMT and E/M service on the same date.

Below find the description for the preservice, intraservice and postservice work for the E/M Service Code most frequently reported to CMS in CY 2013. The descriptions illustrate the work of the E/M service is significantly, separately, identifiable and above and beyond the usual preservice and postservice work of the OMT service.

E/M service code 99213: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

Description of Pre-Service Work:

Review the medical history form completed by the patient and vital signs obtained by clinical staff.

Description of Intra-Service Work:

- Obtain an expended problem focused history (including response to treatment at last visit and reviewing interval correspondence or medical records received)*
- Perform an expended problem focused examination*
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (low complexity medical decision making)*
- Discuss diagnosis and treatment options with the patient
- Address the preventive health care needs of the patient
- Reconcile medication(s) o Write prescription(s) o Order and arrange diagnostic testing or referral as necessary

Description of Post-Service Work:

- Complete the medical record documentation
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after the visit
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit
- Receive and respond to any interval testing results or correspondence
- Revise treatment plan(s) and communicate with patient, as necessary

OMT Coding Information:

CPT/HCPCS Codes

98925 Osteopathic Manipulative Treatment (OMT); 1-2 Body Regions Involved
98926 Osteopathic Manipulative Treatment (OMT); 3-4 Body Regions Involved
98927 Osteopathic Manipulative Treatment (OMT); 5-6 Body Regions Involved
98928 Osteopathic Manipulative Treatment (OMT); 7-8 Body Regions Involved
98929 Osteopathic Manipulative Treatment (OMT); 9-10 Body Regions Involved

ICD-9/ICD-10 Diagnosis Codes

ICD-9 Codes:

739.0 Head region
739.1 Cervical region
739.2 Thoracic region
739.3 Lumbar region
739.4 Sacral region
739.5 Pelvic region
739.6 Lower extremities
739.7 Upper extremities
739.8 Rib cage region
739.9 Abdomen and viscera region

ICD-10 Codes:

M99.00 Segmental and somatic dysfunction of head region
M99.01 Segmental and somatic dysfunction of cervical region
M99.02 Segmental and somatic dysfunction of thoracic region
M99.03 Segmental and somatic dysfunction of lumbar region
M99.04 Segmental and somatic dysfunction of sacral region
M99.05 Segmental and somatic dysfunction of pelvic region
M99.06 Segmental and somatic dysfunction of lower extremity
M99.07 Segmental and somatic dysfunction of upper extremity
M99.08 Segmental and somatic dysfunction of rib cage
M99.09 Segmental and somatic dysfunction of abdomen and other regions

OMT Techniques are listed below (Please refer to the AACOM Glossary of OMT Terminology for more information)

Active method
Articulatory method
Articulatory treatment
Articulatory (ART)
Balanced ligamentous tension (BLT)
Chapman reflex
Combined method
Combined treatment
Compression of the forth ventricle (CV-4)
Counterstrain (CS)
Cranial Treatment (CR)
CV-4
Dalrymple treatment
Direct method
Exaggeration method
Exaggeration technique
Facilitated oscillatory release technique (FOR)
Facilitated positional release (FPR)
Fascial release treatment
Fascial unwinding
Functional method
Galbreath treatment
Hepatic pump
High velocity/low amplitude technique
Hoover technique
Indirect method (I/IND)
Inhibitory pressure technique
Integrated neuromusculoskeletal release
Jones technique
Ligamentous articular strain technique (LAS)
Liver pump
Lymphatic pump
Mandibular drainage technique
Mesenteric release technique
Muscle energy
Myofascial release (MFR) direct and indirect
Myofascial technique
Myotension
Osteopathic in the Cranial Field (OCF)
Passive method
Pedal pump
Percussion vibrator technique
Positional technique
Progressive inhibition of neuromuscular structure (PINS)
Range of motion technique
Soft tissue technique
Spencer technique
Splenic pump technique

Spontaneous release by positioning
Springing technique
Still technique
Strain-Counterstrain ®
Thoracic pump
Thrust technique (HVLA)
Toggle technique
Traction technique
V-spread
Ventral techniques

Sources of Information

American Osteopathic Association Osteopathic Manipulative Treatment Coding Instructional Manual Second Edition (2012)
American Osteopathic Association (2014). Position paper on Evaluation and Management services (E/M) with Osteopathic Manipulative Treatment (OMT).
American Osteopathic Association (1998). Protocols for Osteopathic Manipulative Treatment (OMT).
American Association of Colleges of Osteopathic Medicine Glossary of Osteopathic Glossary of OMT Terminology.
American Medical Association (AMA) Current Procedural Terminology (CPT©) 2015 Manual
American Medical Association (AMA) Relative Value Update Committee (RUC) Database

Source: H635-A/20

Status: 2015; 2020 Reaffirmed

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Non-Physician Clinicians

Policy Statement

The American Osteopathic Association (AOA) has adopted the attached policy paper as its position on non-physician clinicians including appropriate onsite supervision.

Over the course of the past century, scientific and technological advancements have led to improvements in the treatment of disease and standards of patient care. As a result, the standardized medical education, supervised postgraduate ("residency") training and examination series that physicians in the United States are required to complete in order to obtain an unlimited medical license has increased as well. At the same time, however, some states are creating legislative pathways to independent medical practice for other types of clinicians, despite the absence of nationally standardized education, training and testing pathways for these clinician groups, or evidence regarding patient safety outcomes.

The current DO/MD medical model, in which medical students and resident physicians are required to demonstrate their ability to safely provide care to patients under the supervision of fully licensed physicians, leading to greater autonomy over time, has proven its ability to provide physicians with the complete knowledge and skill base needed to ensure patient safety and optimize outcomes. in addition, most states impose additional continuing medical education (CME) requirements, and many physicians elect to undergo rigorous certifying board examinations to demonstrate excellence in a particular specialty, which helps to ensure that physicians remain trained to provide the current highest standard of patient care over the course of their careers.

Thus, it is appropriate that the practice of medicine and the quality of medical care are remain the responsibility of properly licensed physicians, who are the only clinician group properly trained, licensed and regulated according to uniform laws governing medical licensure in the United States. the American Osteopathic Association (AOA) further values the unique training and contributions of all members of the patient care team and supports the concept of uniform licensure pathways for non-physician all clinician groups, based upon scope of practice. the AOA further supports appropriate physician involvement in patient care provided by non-physician clinicians and opposes any legislation or regulations which would authorize the independent practice of medicine by an individual who has not completed the state's requirements for physician licensure.

As non-physician clinicians continue to seek wider roles, public policy dictates that patient safety and proper patient care should be foremost in mind when the issues encompassing expanded practice rights for non-physician clinicians – autonomy, scopes of practice, prescriptive rights, liability and reimbursement, among others – are addressed.

A. Patient Safety. The AOA supports the "team" approach to medical care, with the physician as the leader of that team. The AOA further supports the position that patients should be made clearly aware at all times whether they are being treated by a non-physician clinician or a physician. The AOA recognizes the growth of non-physician clinicians and supports their rights

to practice with appropriate physician involvement within the scope of the relevant state statutes.

B. Independent Practice. It is the AOA's position that roles within the "team" framework must be clearly defined, through established state-level supervisory protocols and signed agreements, so physician involvement in patient care is sought when a patient's case dictates and patients can rest assured that physician involvement in their care will remain the same regardless of practice setting within the state. The AOA feels nonphysician clinician professions that have traditionally been under the supervision of physicians must retain physician involvement in patient care. Those non-physician clinician professions that have traditionally remained independent of physicians must involve physicians in patient care when warranted. further, all non-physician clinicians must refer a patient to a physician when the patient's condition is beyond the non-physician clinician's scope of education, training or expertise.

C. Liability. The AOA endorses the view that physician liability for non-physician clinician actions should be reflective of the quality and degree of supervision being provided and should not exonerate the non-physician clinician from liability. It is the AOA's position that non-physician clinicians acting providing care in independent practice states autonomously of physicians should be regulated and disciplined by the entities responsible for regulating and disciplining physicians (i.e. state medical boards), to ensure that all clinicians who are independently practicing medicine are held to the same standard of care and the equivalent degree of liability as that of a physician. Within this independent practice framework, to that end, the aoa further also believes that non-physician clinicians should be required to obtain equivalent malpractice insurance in those states that currently require to physicians in states that currently require physicians to possess malpractice insurance.

Source: H640-A/20

Status: 2000, 2005 Revised; 2010 Revised; 2015 Reaffirmed; 2018 Revised; 2020 Reaffirmed as Amended

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Prior Authorization

Policy Statement

The American Osteopathic Association (AOA) adopts the following policy and principles statement on prior authorization.

Prior authorization requirements have been found to result in care delays that place patients at risk and to increase provider burden. In order to ensure that prior authorization is implemented in an appropriate manner that minimizes burden and risk, the AOA believes that implementation of PA by payers and pharmacy benefit managers should abide by the following principles:

- Prior authorizations should be clinically relevant, evidence-based, transparent, and as minimally intrusive on the physician, medical staff, and patient as possible.
- Prior authorization programs that negatively impact access to care, delay treatment, result in abandonment, increase cost of care and administrative costs, do not align with recognized clinical practice guidelines, or have a negative impact on quality of care or outcomes should be discontinued.
- Payors should appropriately compensate providers for complying with utilization review.
- Prior authorization request forms should be standardized and electronic whenever feasible to promote procedural uniformity and reduce administrative burden.
- Allow continuation of medications already being administered or prescribed when a patient changes health plans and not allow changes without discussion and approval of the ordering physician.
- Providers should be notified of changes to prior authorization requirements at least 45 days prior to change.
- Payors and Plans should be required to report a list of services and prescription medications subject to prior authorization and corresponding denial, delay, and approval rates.
- Prior authorization requirements should be minimized as much as possible and eliminate the application of prior authorization to services and prescription medications that are routinely approved
- There should be an easily accessible and responsive direct communication tool to resolve conflicts between health plans and ordering physicians

As part of its efforts to advocate for these principles and ensure their incorporation into policy, the AOA will advocate for legislation and regulatory changes that would require payers and pharmacy benefit managers to:

- Disclose in sales, promotional materials and advertising that their products utilize a prior authorization process which may result in a delay in or denial of diagnosis and or treatment which may be detrimental to the patient's health or well-being

- Consider a physician’s attestation of clinical diagnosis or order sufficient documentation of medical necessity for durable medical equipment

- Include in contracts with healthcare providers hold harmless clauses that indemnify healthcare providers against financial loss due to injury to a patient as a result of the payor’s failure or refusal to grant a prior authorization request in a timely manner

- Provide appropriate notice to patients and physicians when formulary and benefit changes are made

- Include a correct phone number and web address on the patient identification card for initiating the prior authorization process; Make all forms used in the prior authorization process readily available to healthcare providers, including EMR templates

- Publish and make available to the public all requirements for prior authorization and follow those published policies

- Provide sufficient knowledgeable staff to ensure that healthcare providers are able to contact medical claims payers and pharmacy benefit managers without average hold times exceeding 10 minutes

- Compensate medical practices and healthcare providers for the cost of time spent on inappropriately denied PA requests

- To identify and hold accountable the payor’s medical director/claim adjudicator for the results of their decisions

Source: H642-A/20

Status: 2020; Note previous policy numbers of H343-A/13, H602-A/15; H632-A/17, H635-A/19, H637-A/19, and H640-A/16 have been sunset and policy H642-A/20 is the current policy.

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Postpartum Depression

Policy Statement

The American Osteopathic Association (AOA) encourages its members to participate in continuing medical education programs on postpartum depression (PPD); urges colleges of osteopathic medicine (COMs) and osteopathic state and specialty associations to offer CME on PPD as part of their educational offerings; and endorses the use of screening tools and encourage the measurement of outcomes in their use.

Source: H646-A/20

Status: 2003; 2008; 2013 Reaffirmed as Amended; 2020 Reaffirmed

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Managed Care Plans – Service, Access and Costs in

Policy Statement

The American Osteopathic Association (AOA) supports efforts to expand the use of variable co-pays that support program costs. The AOA also supports efforts to design benefits that align consumer needs, accountability and individual physician incentives.

Source: H647-A/20

Status: 1999; 2004 Revised; 2009 Reaffirmed as Amended; 2014 Reaffirmed as Amended; Reaffirmed.

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Researching Patient Safety and Provider Qualifications

Policy Statement

The American Osteopathic Association (AOA) encourages independent research on the qualification and outcomes of nurse practitioners and other midlevel providers that practice independently; and that the AOA research & public health staff perform an analysis of current, valid and published research on clinical outcomes, resource utilization and malpractice experience for independently practicing NPS and PAS and provide this information to osteopathic physicians.

Source: H648-A/20

Status: 2020 Reaffirmed as Amended

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Support the Bolstering of Veteran Health Administration Resources through Provider Pay Reform

Policy Statement

The American Osteopathic Association (AOA) support both staffing management and competitive pay reform at the Veterans' Health Administration (VHA) to ensure that a full, stable workforces, as budgeted by the Department of Veterans Affairs, is available to meet the health needs of the United States veteran population.

Source: H649-A/20

Status: 2020

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A Proclamation Regarding the Inaccurate Portrayals of U.S. Trained DOs in Media

Policy Statement

The leadership and members of the American Osteopathic Association (AOA) condemn the poorly researched and patently incorrect statements regarding the scope of practice of U.S. trained DOs made by journalists.

The AOA will continue ongoing efforts using social media and other means to educate the public and dispel inaccuracies of U.S. trained DOs. The AOA encourages its members, affiliated organizations, our patients and our Allopathic colleagues to use social media and other means to accurately represent the profession of Osteopathic Medicine to the public.

The AOA will continue to provide online resources and support to its members and advocates to develop a grassroots social media campaign to further the understanding of the profession of Osteopathic Medicine by the public.

The AOA on behalf of the osteopathic profession expresses appreciation and gratitude to the journalists, organizations, and other persons that support an accurate portrayal of osteopathic medicine and osteopathic physicians in the media.

Source: H651-A/20

Status: 2020

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Advocating for Coverage of Elemental Formula in State, Federal, and Private Insurance Programs

Policy Statement

The American Osteopathic Association supports legislation which advocates for the coverage of medically necessary elemental pediatric formula under Medicaid and private insurance plans.

Source: H601-A/21

Status: 2021

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Telehealth

Policy Statement

The American Osteopathic Association (AOA) has updated the policy statement on telehealth as outlined below.

Source: H603-A/21

Status: 2021

AOA Telehealth Policy

The COVID-19 public health emergency caused by the highly contagious sars-cov-2 virus has demonstrated the need to broaden and optimize the use and delivery of healthcare services through telehealth to prevent the spread of the outbreak. With the rapid pace of advancement in technology, telehealth is an evolving practice – both in the types of services furnished, and the tools used to expand access to medical care. Telehealth is a tool used not only to provide direct services to a patient via information technology, but also specialist and primary care consultations, the online storage and sharing of medical information, imaging services through digital transmissions and the interpretation of images, remote patient monitoring, and medical education.

The practice of medicine via electronic and technological means has been occurring for decades. As technology advances and the breadth of medical practice in this area expand, there is an increasing call to regulate patient care delivered through technological resources. Advocates for telehealth argue that it provides improved access to medical care and services to patients in rural or underserved areas. They also emphasize that it allows for easier access to care for immobile patients and those with limited mobility. Cost-effectiveness, through reduced travel times, is also noted as a cause for increased patient demand for health care services through telehealth.

Despite its advantages, opponents raise concerns over the lack of regulation and oversight to control this practice. The primary issues involving telehealth are: (1) geographical and site-of-service restrictions: (2) licensure of out-of-state practitioners who use technology to treat patients in a state where they are not licensed to practice; (3) technological problems and barriers; (4) reimbursement issues regarding payment for services rendered; and (5) quality of care.

Access, Efficiency and Quality

The U.S. Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) have identified several benefits of telehealth. Virtual services limit physical contact and exposure to infectious diseases, shorten in-office wait times, eliminate commuting time and travel expenses, reduce time off from work and the need for childcare, and provide access to medical care in rural and underserved communities.

Despite the advances in telecommunication technology, some stakeholders are concerned that a lack of regulation and oversight may undermine the quality of care provided, or create an opportunity for fraud and abuse. Care deemed to be below the acceptable quality standard can be addressed either via the disciplinary action of a state medical board or via civil legal action (medical malpractice claims). Liability rules vary state by state and concerns exist over the determination of venue when a provider is utilizing telehealth across state lines. Additionally, standard of care must be established and may vary between face-to-face encounters and telehealth encounters; although, many providers argue against this variation.

Liability Concerns

One issue that arises under the discussion of advancing telehealth is the question of jurisdiction for liability cases. This includes cases of medical malpractice, where a physician licensed to practice in two or more states practices medicine over state lines through electronic means, and an adverse event occurs.

Current state and federal statutes and case law provide a remedy to overcome this barrier. Patients are provided a pathway to legal recourse in the state where the accident occurred, if there is a reasonable expectation for that harm to have occurred there. If the patient can provide evidence confirming that location, (IP address, for example) and did not attempt to deceive the physician as to their location. Under this established system, any time a physician is choosing to perform telehealth, they should have the expectation that they are choosing to be held liable under another state's laws if an adverse event occurs.

Licensure

Telehealth is a broad area and is not regulated by one specific board or oversight body. There is no standard for Telehealth education and no certification in the provision of telehealth. Therefore, the burden of oversight currently falls on the state medical boards. Each board defines care that meets an acceptable quality somewhat differently. State licensure requirements also diverge with significant differences in ~~testing,~~ postgraduate education and continuing medical education requirements. Additionally, scopes of practice varies by state with no overall standard in regards to prescription authority or practice rights. Finally, uniformity fails to exist in what constitutes a visit (establishment of the “physician-patient relationship”), with some states requiring a face-to-face visit before a telehealth relationship can be established. Due to these differences, some advocates have promoted the concept of national licensure. They believe that a national license for the practice of medicine would eliminate barriers that prevent widespread use of telehealth.

The AOA supports state-based licensure and discipline oversight, believing that states should have the right to directly regulate and provide oversight for services being provided to their citizens. Concerns have been expressed about who would assume responsibility for disciplinary action against providers if a national medical license was initiated. Currently, protection of the residents of the state is a top function and core value of the state licensing boards.

Conclusion

The AOA recognizes the benefits of online technology to the medical field, and its ability to assist many patients who may not have access to medical care.

The AOA further recognizes the need to provide a broad framework that establishes payment and policy recommendations to effectively advocate for telehealth at the national level, while providing enough flexibility to allow each state to incorporate policies that meet the health care needs of their citizens.

The AOA supports that a physician is practicing medicine, in the absence of physical interaction, when medical services are being provided through simultaneous two-way communication, recognizing that some services may require appropriate and corresponding delays in said communication.

The AOA supports that the utilization of technology in patient care should be used to increase access to care, and must not be used in a way that would diminish patient centered comprehensive personal medical care or the quality of care being provided to the patient. To this end, the AOA supports the concept of telehealth and advocates that public and private payers adopt payment systems that are inclusive of telehealth, and payment parity for professional advice, consultation and development of patient treatment plans provided to patients, family members or designee via telehealth.

The AOA supports that the standard of care provided through the use of technology should be equivalent to that of care provided when the physician and patient are within close physical proximity.

The AOA supports that the technological network being used to deliver patient care must have protocols in place that ensure the stability and security of that network to comply with applicable state and federal laws regarding patient privacy protections.

The AOA supports that the scope of care being delivered by the physician and other health care providers through telehealth should not exceed education training and applicable state and federal law.

The AOA supports that the state-based licensure and ability of states to govern activities within their borders is paramount and would oppose any national licensure or efforts to preempt state statutes.

The AOA supports that malpractice claims that arise from care provided through technological means, when the physician and patient in separate jurisdictions, should be adjudicated under the process currently utilized by the judicial system; whereby, the plaintiff has the ability to determine the venue where the case is filed, within the constraints of that system.

The AOA supports physicians must provide complete transparency to their patients regarding their location, jurisdiction of licensure and any limitations of the technology used to deliver care.

The AOA supports that as physicians provide care in a variety of new ways, including telehealth, advanced technology can be used to improve patient care. The AOA further supports that telehealth policies directly tie into the Patient-Centered Medical Home (PCMH) model for care and other value-based care arrangements, and recognizes that we must simultaneously implement advancements in telehealth in order to be successful in new alternative payment models.

The AOA supports collaboration with the American Medical Association and other stakeholders to advocate for legislation or an executive order to mandate that all health insurance plans, including those issued by the centers for Medicare & Medicaid services and entities covered under Employee Retirement Income Security Act (ERISA) law continue to reimburse for telehealth services at a level that is commensurate with a face-to-face visit.

The AOA supports efforts to address educational and operational barriers that interfere with implementation of telehealth in physician offices, and believes that every effort should be made to allow telehealth services to be provided by the patient's attending physician, rather than by physicians or clinicians the patient is unaffiliated with or is not referred by the patient's primary care physician.

The AOA will monitor developments in telehealth on an ongoing basis and update this policy as needed.

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Patient Access to Home Health Services

Policy Statement

The American Osteopathic Association (AOA) supports policies that will improve patient access and coverage to home healthcare services while prioritizing patient safety and promoting quality of home health services.

Source: H604-A/21

Status: 2021

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Disaster Relief Volunteers

Policy Statement

As part of volunteer service, the American Osteopathic Association recommends: (1) encourage osteopathic physicians seek out appropriate training in disaster response, (2) encourages all osteopathic physicians to enroll as a volunteer to provide medical care during disasters before the next disaster strikes; (3) encourages all DOs to consider joining the U.S. Surgeon General's Medical Reserve Corps or registering with their state or local Emergency System for Advanced Registration of Volunteer Health Profession Program (ESAR-VHP); (4) encourages osteopathic physicians who wish to volunteer to provide domestic or international emergency medical assistance to contact the humanitarian organizations; and (5) encourages the federal and state governments to work with the medical licensing boards to produce pathways and data resources that can hasten licensed medical aid to disaster victims during public health emergencies.

Source: H605-A/21

Status: 2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed as Amended

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Electronic Medical/Health Record Exemption without Penalty

Policy Statement

The American Osteopathic Association supports an exemption to financial penalties to solo and small group practices that do not implement electronic medical records.

Source: H606-A/21

Status: 2011; 2016 Reaffirmed; 2021 Reaffirmed

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Physician Administered OMT

Policy Statement

The American Osteopathic Association actively opposes the use of Osteopathic Manipulative Treatment (OMT) / Current Procedural Terminology (CPT) codes by groups other than fully-licensed osteopathic and allopathic physicians and will work diligently to reverse such policies, wherever they exist, that allow non-physicians to utilize OMT/CPT codes for reimbursement.

Source: H607-A/21

Status: 1994; 1999 Reaffirmed as Amended; 2004 Reaffirmed; 2016 Reaffirmed; 2021 Reaffirmed

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Mandatory Participation in Insurance Plans

Policy Statement

The American Osteopathic Association opposes any public policy that requires mandatory participation of physicians in any insurance plan, including Medicare or Medicaid and private insurance plans.

Source: H608-A/21

Status: 1994; 1996 Reaffirmed as Amended, 2001; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed as Amended; 2021 Reaffirmed

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Medicare Claims Coding – Centers for Medicare and Medicaid Services Communications with Physicians

Policy Statement

The American Osteopathic Association urges the Centers for Medicare and Medicaid Services officials to require its Medicare administrative contractors provide thorough, current, written information on the preparation and coding of Medicare claims to all physicians prior to the implementation of any new policies or programs.

Source: H609-A/21

Status: 1999; 2006 Reaffirmed; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed

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Physician Negotiation Rights

Policy Statement

The American Osteopathic Association will support public policies that allow physicians to jointly negotiate with insurers thereby creating an equitable basis for negotiations between these parties.

Source: H610-A/21

Status: 2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed as Amended; 2021 Reaffirmed as Amended

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Readmission Rates by the Centers for Medicare and Medicaid Services as a Criterion for Ranking – Opposition to use of

Policy Statement

The American Osteopathic Association is opposed to the use of readmission rates as a criterion for deciding payment for physicians and the use of readmission rates as a criterion for ranking the quality of care provided by physicians.

Source: H611-A/21

Status: 2011; 2016 Reaffirmed; 2021 Reaffirmed

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Current Procedural Terminology (CPT) Codes –Blending Rates

Policy Statement

The American Osteopathic Association is opposed to blending of payment rates by insurers for CPT codes.

Source: H612-A/21

Status: 2006; 2011 Reaffirmed as Amended; 2016 Reaffirmed; 2021 Reaffirmed as Amended

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Health Insurance Exchanges

Policy Statement

The American Osteopathic Association adopts the following “Principles for State Health Insurance Exchanges” to assist states in the formation of health insurance exchanges and will communicate these principles to the Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS), governors and state legislatures.

Source: H613-A/21

Status: 2011; 2016 Reaffirmed as Amended; 2021 Reaffirmed

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Access to Care – Network Adequacy and Coverage

Policy Statement

The American Osteopathic Association (AOA) will advocate for public and private payors ensuring plan coverage for all medically necessary services, regardless of availability within the service area of its beneficiaries, and supporting state regulators as the primary enforcer of network adequacy requirements.

The AOA supports requiring provider terminations without cause be done prior to the enrollment period, allowing physicians to be added to the network at any time, and requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy.

The AOA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.

The AOA will advocate for public policies to require out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.

The AOA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities; and, that physician and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.

The AOA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities, and will advocate for laws that prohibit health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.

The AOA will advocate that health plans be required to document to regulators that they have met requisite standards of network adequacy for hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities.

Source: H614-A/21

Status: 2016; 2021 Reaffirmed

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Third Party Insurer Coverage Process Reform

Policy Statement

The American Osteopathic Association (AOA) supports the development of model legislation and/or regulations to require that Medicare, commercial insurance companies, state Medicaid agencies, or other third party insurers utilize transparent and accountable processes for developing and implementing coverage decisions and policies.

The AOA will advocate that public and private insurers and benefit management companies develop transparent clinical protocols as well as formal processes to write / revise them; that those processes should seek input from the relevant physician organizations; and that such clinical coverage protocols should be easily and publicly accessible on their websites.

The AOA will advocate that when public and private insurers and benefit management companies make changes to or revise clinical coverage protocols, said companies must inform all insured individuals and participating providers in writing no less than 90 days prior to said change(s) going into effect; and, be it further

Through legislative and/or regulatory efforts the AOA will advocate that when Medicare Administrative Contractors (MAC) propose new or revised Local Coverage Determinations (LCD), said Contractors must: 1. Conduct Carrier Advisory Committee meetings in public, with minutes recorded and posted to the Contractor's website; and 2. Disclose the rationale for the LCD, including the evidentiary standard upon which it is based when releasing an approved LCD. Through legislative and/or regulatory efforts the AOA will advocate that CMS adopt a new LCD reconsideration process that allows for an independent review of a MAC's payment policies by a third-party empowered to make recommendations to affirm, withdraw or revised said policies to the Secretary of HHS; and that that MACs shall be prohibited from adopting another MAC's LCD without first undertaking a full and independent review of the underlying science and necessity of such LCD in their jurisdiction.

Source: H615-A/21

Status: 2016; 2021 Reaffirmed as Amended

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Merit-Based Incentive Payment System (MIPS) & Alternative Payment Models (APMS)

Policy Statement

The American Osteopathic Association (AOA) will endeavor to educate osteopathic physicians on the Medicare Access and Children's Health Insurance Program (CHIP) reauthorization act of 2015 (MACRA) and the newly emerging payment models, including Merit Based Incentive Payment System (MIPS) AND Alternative Payment Models (APMS), resulting from the act and how these payment models might affect practicing physicians by developing and disseminating broadly available educational materials on MACRA and resulting payment models.

Source: H616-A/21

Status: 2016; 2021 Reaffirmed

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Health Insurer Consolidation

Policy Statement

The American Osteopathic Association (AOA) supports the application of strict and necessary scrutiny by appropriate governmental agencies, including but not limited to the Department of Justice State Attorneys General, Federal Trade Commission, and State Insurance Commissioners, to any consolidation of health insurers and that each health insurer consolidation should be evaluated on protecting the interests and needs of the health care consumer, including patient access**,** and choice among multiple insurers. the necessity of any merger within the health insurance industry must demonstrate a benefit to patients by improving patient access and by meeting the quadruple-aim of enhancing patient experience, improving population health, reducing costs, and improving the work life of health care providers, including clinicians and staff.

Source: H617-A/21

Status: 2016; 2021 Reaffirmed as Amended

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Medicare Medical Necessity Certification Requirements

Policy Statement

The American Osteopathic Association (AOA) supports reasonable efforts to prevent Medicare waste, fraud, and abuse, and there by calling on the Center for Medicare and Medicaid Services (CMS) to evaluate its medical necessity certification requirements including the amount of waste fraud and abuse detected and prevented by such measures, the administrative burden imposed on physician practices, and the rate of denial of legitimate medical supplies and equipment. The AOA encourages CMS to develop a more efficient and less burdensome approach to medical necessity certification.

Source: H618-A/21

Status: 2016; 2021 Reaffirmed as Amended

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Expanding Gender Identity Options on Physician Intake Forms

Policy Statement

The American Osteopathic Association (AOA) supports the inclusion of a two-part demographic inquiry on patient intake forms, requesting patients indicate both their assigned sex at birth (male, female, intersex) and gender identity (male, female, transgender male, transgender female, nonbinary, additional category with blank for patient to complete).

Source: H619-A/21

Status: 2016; 2021 Reaffirmed as Amended

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Osteopathic Neurologic and Psychiatric Standard of Care

Policy Statement

The American Osteopathic Association acknowledges the role osteopathic manipulative treatment (OMT) has in the specialty of Osteopathic Neurology and Psychiatry and agrees that when OMT is chosen to be utilized with appropriately selected patients, therapeutic boundaries will be maintained and respected.

Source: H600-A22

Status: 2010; 2017 Reaffirmed; 2022 Reaffirmed

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Adjustment to Primary Care Incentive Program

Policy Statement

The American Osteopathic Association is supportive of at least 10% incentive payment to primary care physicians and non-physician providers (NPPs), supervised by primary care physicians, who perform the Primary Care Services.

Source: H603-A22

Status: 2012; 2017 Reaffirmed as Amended; 2022 Reaffirmed as Amended

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Physician Depositions

Policy Statement

The American Osteopathic Association believes that physicians being deposed should have the right to review and amend the deposition prior to submission and be provided a complete, final copy of the deposition.

Source: H604-A22

Status: 2012; 2017 Reaffirmed; 2022 Reaffirmed

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The Practice of Osteopathic Medicine Discrimination

Policy Statement

The American Osteopathic Association supports the inclusion of osteopathic physicians in all healthcare delivery systems; opposes restraint of trade and supports the ability of all osteopathic physicians to practice freely in all institutions, as qualified by training and experience as defined and specified by the AOA; and opposes discrimination against osteopathic physicians.

Source: H605-A22

Status: 1987; 1992 Reaffirmed as Amended; 1997 Reaffirmed; 2002 Reaffirmed; 2007 Reaffirmed as Amended; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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Drug Prescribing, Including Elderly Patients

Policy Statement

The American Osteopathic Association supports measures to significantly reduce the problems of over-medication, under-medication and / or harmful drug interactions in all patients, including the elderly population.

Source: H606-A22

Status: 2002, 2007 Reaffirmed as Amended; 2012 Reaffirmed; 2017 Reaffirmed as Amended; 2022 Reaffirmed as Amended

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Human Immunodeficiency Virus (HIV) – Positive Status as a Disability for Physicians

Policy Statement

The American Osteopathic Association supports efforts to require all disability insurance contracts to recognize HIV positive status as a disability for all physicians, regardless of specialty, provided that the physician can demonstrate that this status has caused a significant loss of patients, income or privileges.

Source: H607-A22

Status: 1992; 1997 Reaffirmed as Amended; 2002 Reaffirmed; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed; 2022 Reaffirmed

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Health Care Fraud and Abuse

Policy Statement

The American Osteopathic Association continues to pledge its full cooperation and support of all reasonable and appropriate efforts by the federal government and the states to stop all fraud and abuse in health care.

Source: H608-A22

Status: 1992;1997 Reaffirmed; 2002 Reaffirmed; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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Military Medical Readiness

Policy Statement

The American Osteopathic Association supports efforts by the Department of Defense which encourage the voluntary participation of osteopathic physicians in the military and improves the military medical readiness of America.

Source: H609-A22

Status: 1987; 1992 Reaffirmed as Amended; 1997 Reaffirmed; 2002 Reaffirmed; 2007 Reaffirmed; 2012 Reaffirmed; 2017 Reaffirmed; 2022 Reaffirmed

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Payment For Psychiatric Diagnoses and Treatment by Primary Care Physicians

Policy Statement

The American Osteopathic Association strongly objects to any insurance plan refusal to pay primary care physicians for treating patients with psychiatric diagnoses without a referral from the behavioral medicine agency or provider; will make every effort to influence these insurers to reverse this policy and allow primary care physicians to provide care for these patients and be paid for these services; and will communicate with the regulators and respective third-party payers to eliminate the mandatory referral in order to be paid when proper documentation is provided.

Source: H610-A22

Status: 2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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Physician Fines Imposed by Third Party Payors

Policy Statement

The American Osteopathic Association opposes all punitive fees, hold backs or other financial penalties levied on physicians for acts committed by patients that are not under the absolute control of the physician.

Source: H611-A22

Status: 2007; 2012 Reaffirmed; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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Health Care Insurance Options

Policy Statement

The American Osteopathic Association supports legislation that requires employers who are obligated by law to provide insurance to offer more than one option for health insurance.

Source: H612-A22

Status: 1986; 1991 Reaffirmed as Amended, 1992, 1997; 2002 Reaffirmed as Amended; 2007; 2012 Reaffirmed as Amended; 2017 Reaffirmed as Amended; 2022 Reaffirmed

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Human Immunodeficiency Virus (HIV) Consent Form Elimination

Policy Statement

The American Osteopathic Association supports the elimination of the requirement of physicians and healthcare settings to have consent forms completed before an HIV test.

Source: H614-A22

Status: 2017; 2022 Reaffirmed

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Direct Primary Care

Policy Statement

The American Osteopathic Association supports the direct primary care model of practice and specifies that it is not insurance. Additionally, the AOA supports patients' payments to direct primary care practices as qualified medical expenses eligible for Health Savings Accounts through federal changes to Internal Revenue Code 213(d) and 223(c) and a physician's ability to dispense prescription medications from their office in accordance with applicable federal and state laws. The AOA supports mechanisms allowing Medicaid and Medicare patients access to direct primary care services while preserving physician autonomy.

Source: H615-A22

Status: 2017; 2022 Reaffirmed as Amended

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Opposition to the Practice of LGBTQIA2S+ Conversion Therapy or Reparative Therapy

Policy Statement

The American Osteopathic Association affirms that identifying as lesbian, gay, bisexual, transgender, questioning queer, or other than heterosexual (LGBTQIA2S+) is not a mental disorder. Sexual orientation and gender identity are not mental disorders.

The AOA strongly opposes the practice of conversion therapy, reparative therapy, or other techniques aimed at changing a person's sexual orientation or gender identity as the preferred outcome.

The AOA supports potential legislation, regulations, or policies that oppose the practice of conversion therapy, reparative therapy, or other techniques aimed at changing a person's sexual orientation or gender identity as the preferred outcome.

Source: H616-A22

Status: 2017; 2022 Reaffirmed as Amended

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Patient Interpreters

Policy Statement

The American Osteopathic Association supports efforts to remove from Section 1557 of the Affordable Care Act the unfunded mandate on physicians to provide interpreters for those patients with Limited English Proficiency (LEP) by revising the current federal policy to include adequate reimbursement for physicians for patient interpreters.

Source: H618-A22

Status: 2017; 2022 Reaffirmed

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AOA Opposition to Merging of State Osteopathic Licensing Boards with State Medical Licensing Boards

Policy Statement

The American Osteopathic Association stands in opposition to the consolidation of any state osteopathic and medical licensure boards. The AOA will actively monitor for activities that threaten separate state osteopathic licensing boards in the states where they exist and will prioritize its resources to oppose efforts to consolidate state osteopathic and medical licensing boards.

Source: H619-A22

Status: 2017; 2022 Reaffirmed as Amended

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Prescription Drug Pricing

Policy Statement

The American Osteopathic Association will advocate for policies that encourage pharmaceutical manufacturers, prescription drug benefit managers, pharmacies, and payers to price drugs and insurance products that cover prescription drugs in order to promote access, affordability, and continued advancement of healthcare quality and innovation.

Source: H620-A/22

Status: 2017; 2022 Reaffirmed as Amended

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Reducing the Waiting Period for Credentialing, Re-Credentialing and Enrollment of Health Care Professionals by Health Plans

Policy Statement

The American Osteopathic Association (AOA) advocate for transparent, unburdensome, timely, and cost-effective credentialing processes; and advocate for legislation, and provide sample language, recommending the reduction of the length of time required for credentialing, recredentialing and enrollment by any health plan to 60 days or less when a clean provider application is submitted to the health plan.

Source: H624-A/22

Status: 2022 Reaffirmed as Amended

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Centers for Medicare and Medicaid Services Policies

Policy Statement

The American Osteopathic Association (AOA) will continue to inform state associations and their members on policies and rules being considered by the Centers for Medicare and Medicaid Services and/or other federal agencies on major patient/physician issues and encourages the state associations to provide their members with the information and take an active role in responding to CMS on policies and rules pertinent to their members, their practices and patients.

Source: H600-A/23

Status: 1998; 2003 Reaffirmed as Amended; 2008 Reaffirmed; 2013; 2018 Reaffirmed; 2023 Adopted

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Combating Pharmaceutical Evergreening to Decrease Healthcare Costs and Increase Quality, Competition

Policy Statement

The American Osteopathic Association (AOA) advocates for and supports all efforts to combat evergreening defined as the practice of extending the patent on a drug by filing a new patent for a marginal modification in shape, dose, or color in such a way that no efficacious benefit is made.

Source: H601-A/23

Status: 2018; 2023 Adopted as Amended

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Comprehensive Gun Violence Reform

Policy Statement

The American Osteopathic Association (AOA) joins physician like-minded organizations in the call for Congressional legislation that:

1. Labels gun violence as a national public health issue.
2. Funds appropriate research on gun violence as part of future federal budgets.
3. Establishes constitutionally appropriate restrictions on the manufacturing and sale, for civilian use, of large-capacity magazines and firearms with features designed to increase their rapid and extended killing capacity.

Source: H602-A/23

Status: 2018; 2023 Adopted

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Increasing the Education and Availability of Naloxone Use for Opioid Overdose

Policy Statement

The American Osteopathic Association (AOA) supports the continued availability of naloxone as an over-the-counter medication, and the education and training of its use for patients at risk of overdose, family members, and caregivers to prevent opioid / opiate related deaths.

Source: H603-A/23

Status: 2018; 2023 Adopted as Amended

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Recognizing Sexual Assault Survivors' Rights

Policy Statement

The American Osteopathic Association (AOA) advocates for the legal protection of sexual assault survivors' rights as defined by the Survivors' Bill of Rights Act of 2016.

Source: H604-A/23

Status: 2018; 2023 Adopted

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Urge Congress to Retain DACA Protections

Policy Statement

The American Osteopathic Association (AOA) supports Deferred Action for Childhood Arrivals (DACA) medical students, residents and physicians; and the AOA supports and urges Congress to pass comprehensive immigration legislation that accommodates and resolves DACA status.

Source: H605-A/23

Status: 2018; 2023 Adopted as Amended

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Veterans – Health Care for U.S.

Policy Statement

The American Osteopathic Association (AOA) supports adequate health care funding by the federal government to provide health care for all U.S. Veterans at Veterans Health Administration (VHA) facilities and supports federal funding for veterans to utilize non-VHA employed physicians for care in order to improve access and quality of care for American Veterans when VHA facilities cannot provide adequate or timely, or reasonable geographic access.

Source: H606-A/23

Status: 2003; 2008; 2013 Reaffirmed; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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AOA Accreditation of Sponsors Providing Osteopathic Continuing Medical Education (AOA Category 1-A)

Policy Statement

The American Osteopathic Association (AOA) be barred from divesting itself of, through merger, sale or other action, the responsibility of accrediting osteopathic continuing medical education sponsors to any entity other than an AOA recognized osteopathic affiliated organization.

Source: H607-A/23

Status: 2018 Reaffirmed; 2023 Adopted

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Tenets of Osteopathic Medicine

Policy Statement

The American Osteopathic Association (AOA) approves the following consensus statement on the tenets of osteopathic medicine:

1. The body is a unit; the person is a unity of body, mind and spirit.
2. The body is capable of self-regulation, self-healing and health maintenance.
3. Structure and function are reciprocally interrelated.
4. Rational treatment is based upon an understanding of the basic principles of body unity, self-regulation and the interrelationship of structure and function.

Source: H608-A/23

Status: 2008; 2013 Reaffirmed; 2018 Reaffirmed; 2023 Adopted

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Tobacco Use in Entertainment Media

Policy Statement

The American Osteopathic Association (AOA) encourages media producers to eliminate the use of tobacco products in entertainment media.

Source: H610-A/23

Status: 2003; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended; 2023 Adopted

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Cancer Screening – Payment for

Policy Statement

The American Osteopathic Association (AOA) supports cancer screening payment by all payers according to the current evidence-based guidelines.

Source: H611-A/23

Status: 1998, 2003 Reaffirmed as Amended; 2008 Amended and Reaffirmed; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended; 2023 Adopted

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Qualifications for the Practice of OMT and the Coding and Billing for

Policy Statement

The American Osteopathic Association (AOA) believes that only fully licensed physicians are qualified to perform and report osteopathic manipulative treatment (OMT) with current CPT codes. Licensed physicians qualified to provide OMT should not be denied payment based on whether or not a physician has chosen to pursue OMT board certification.

Source: H612-A/23

Status: 2023

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ICD-10 Codes for Laboratory Tests -- Assignment of Appropriate

Policy Statement

The American Osteopathic Association (AOA) supports the use of appropriate single ICD codes to justify the ordering of laboratory tests, if those tests are ordered as part of the evaluation of a disease process or in the context of an already known disease; and the AOA will communicate this policy to the Centers for Medicare and Medicaid Services, the Department of Health and Human Services, health insurance companies, and to the U.S. Congress.

Source: H613-A/23

Status: 1998, 2003 Reaffirmed as Amended; 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended; 2023 Adopted

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Opposing Policies by Third Party Payors that may Negatively Impact the Provision of Healthcare

Policy Statement

The American Osteopathic Association (AOA) in order to preserve the physician-patient relationship and physician clinical judgement as the basis for formulating an individual plan of care, supports policy requiring that third party payors should assist physicians to publish utilization management policies, coverage criteria, their corresponding guidelines, rationales and policies for exceptions to expedite care. The AOA opposes any policies and any practices of third party payors that replace physician clinical judgment with a fixed protocol or potentially less effective medication for required trial of treatment; or prerequisite of diagnostic procedures.

Source: H614-A/23

Status: 2013; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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Physician – Co-Management of a Patient

Policy Statement

The American Osteopathic Association (AOA) supports co-management of a patient, requiring the patient to have an examination by the physician who will be performing the procedure; the physician providing the procedure be available for the follow-up care of the patient; and if for any reason the physician providing the procedure cannot provide the pre- and post-procedural care to the patient, that they/them arrange for an osteopathic or allopathic physician to provide for the pre-procedural and post-procedural care. In cases where a physician is unavailable, non-physician clinicians should be under physician supervision, in accordance with the state law.

Source: H615-A/23

Status: 2002, 2003 Reaffirmed as Amended; 2008 Reaffirmed; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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Recovery Audit Contractors (RACs) – Payment of

Policy Statement

The American Osteopathic Association (AOA) supports removing the contingency payment of Recovery Audit Contractors (RACs) replacing with a flat-rate compensation.

Source: H616-A/23

Status: 2013; 2018 Reaffirmed; 2023 Adopted

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Criminal Liability for Clinical Decisions

Policy Statement

The American Osteopathic Association (AOA) opposes criminal liability for a physician whose clinical decisions were made without malice and in good faith.

Source: H617-A/23

Status: 1998, 2003 Reaffirmed as Amended; 2008 Reaffirmed; 2013 Reaffirmed as Amended; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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Osteopathic Graduate Medical Education

Policy Statement

The American Osteopathic Association (AOA) urges its member physicians to support hospitals that provide osteopathic postdoctoral training with osteopathic recognition through ACGME, which are an integral part of osteopathic medical education.

Source: H618-A/23

Status: 1998; 2003 Reaffirmed as Amended; 2008; 2013 Reaffirmed; 2018 Reaffirmed as Amended; 2023 Adopted as Amended

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Board Certification of Insurance Company Peer Reviewers

Policy Statement

The American Osteopathic Association (AOA) supports state and federal requirements that all insurance company medical directors and any physicians employed by a plan that make medical determinations, including peer-to-peer reviews, be board certified by the American Osteopathic Association or the American Board of Medical Specialties in a specialty or subspecialty related to the requesting physician's specialty and/or subspecialty and to the specific medical needs of the patient for which the requesting physician is seeking prior authorization/pre-certification.

Source: H619-A/23

Status: 2023

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Licensure of Insurance Company Employed Physicians

Policy Statement

The American Osteopathic Association (AOA) supports state and federal requirements that all insurance company physicians and medical directors participating in reviewing, approving, and denying prior authorization and pre-certification requests, and engaging in peer-to-peer reviews and appeals processes, be licensed to practice medicine in the state in which the patient is receiving medical care.

Source: H620-A/23

Status: 2023

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Protection of the Patient-Physician Relationship and Opposition to Physician Penalties for the Provision of Gender Affirming Care

Policy Statement

The American Osteopathic Association (AOA) supports policy that all patients, continue to have access to medically comprehensive evidence-based gender affirming care; and that the AOA opposes any policy that penalizes physicians for recommending and/or providing requested medically comprehensive evidence-based gender affirming care to their patients.

Source: H622-A/23

Status: 2023

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Invisible Disabilities

Policy Statement

The American Osteopathic Association (AOA) encourages increased awareness for patients with invisible disabilities; and that the AOA supports osteopathic physicians to continue to listen to the patient without bias or judgment and provide support as needed.

Source: H623-A/23

Status: 2023

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Improving Pharmaceutical Formulary Accessibility

Policy Statement

The American Osteopathic Association (AOA) supports efforts to mandate payors to timely publish updated medicine formularies online with open accessibility.

Source: H624-A/23

Status: 2023

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Non-Physician Clinician Medical Liability

Policy Statement

The American Osteopathic Association (AOA) has adopted the white paper as its position on non-physician clinicians including appropriate onsite supervision.

NON-PHYSICIAN CLINICIANS WHITE PAPER

Over the course of the past century, scientific and technological advancements have led to improvements in the treatment of disease and standards of patient care. As a result, the standardized medical education, supervised postgraduate ("residency") training and examination series that physicians in the United States are required to complete in order to obtain an unlimited medical license has increased as well. At the same time, however, some states are creating legislative pathways to independent medical practice for other types of clinicians, despite the absence of nationally standardized education, training and testing pathways for these clinician groups, or evidence regarding patient safety outcomes.

The current DO/MD medical model, in which medical students and resident physicians are required to demonstrate their ability to safely provide care to patients under the supervision of fully licensed physicians, leading to greater autonomy over time, has proven its ability to provide Physicians with the complete knowledge and skill base needed to ensure patient safety and optimize outcomes. in addition, most states impose additional continuing medical education (CME) requirements, and many physicians elect to undergo rigorous certifying board examinations to demonstrate excellence in a particular specialty, which helps to ensure that physicians remain trained to provide the current highest standard of patient care over the course of their careers.

Thus, it is appropriate that the practice of medicine and the quality of medical care remain the responsibility of physicians, who are the only clinician group properly trained, licensed, and regulated according to uniform laws governing medical licensure in the United States. The American Osteopathic Association (AOA) values the unique training and contributions of all members of the patient care team and supports the concept of uniform licensure pathways for all clinician groups, based upon scope of practice. The AOA further supports appropriate physician involvement in patient care provided by non-physician clinicians and opposes any legislation or regulations which would authorize the independent practice of medicine by an individual who has not completed the state's requirements for physician licensure.

As non-physician clinicians continue to seek wider roles, public policy dictates that patient safety and proper patient care should be foremost in mind when the issues encompassing expanded practice rights for non-physician clinicians – autonomy, scopes of practice, prescriptive rights, liability, and reimbursement, among others – are addressed.

A. Patient Safety**.** The AOA supports the "team" approach to medical care, with the physician as the leader of that team. The AOA further supports the position that patients should be made clearly aware at all times whether they are being treated by a non-physician clinician or a physician. The AOA recognizes the growth of non-physician clinicians and supports their rights to practice with appropriate physician involvement within the scope of relevant state statutes.

B. Independent Practice**.** It is the AOA's position that roles within the "team" framework must be clearly defined, through established state-level supervisory protocols and signed agreements, so physician involvement in patient care is sought when a patient's case dictates and patients can rest assured that physician involvement in their care will remain the same regardless of practice setting within the state. Further, all non-physician clinicians must refer a patient to a physician when the patient's condition is beyond the non-physician clinician's scope of education, training or expertise.

C. Liability. The AOA endorses the view that physician liability for non-physician clinician actions should be reflective of the quality and degree of supervision being provided and should not exonerate the non-physician clinician from liability. When non-physician clinicians are required to work under the supervision of, or in collaboration with a physician but fail to do so, the non-physician clinician should bear the full liability for their actions**.** It is the AOA's position that non-physician clinicians providing care in independent practice states should be regulated and disciplined by the entities responsible for regulating and disciplining physicians (i.e. state medical boards), to ensure that all clinicians who are independently practicing medicine are held to the same standard of care and the equivalent degree of liability to that end, the AOA also believes that non-physician clinicians should be required to obtain equivalent malpractice insurance to physicians in states that currently require physicians to possess malpractice insurance.

Source: H626-A/23

Status: 2000, 2005 Revised, 2010 Revised, 2015 Reaffirmed, 2018 Revised, 2020 Adopted as Amended; 2023 Adopted as Amended

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In Support of Training and Advocacy for Diverse Patient Populations Including but Not Limited to LGBTQ2+ Within Residency

Policy Statement

The American Osteopathic Association (AOA) encourages all graduate medical education programs to implement inclusive curricula promoting advocacy for patients of all sexual orientations and gender identities.

Source: H628-A/23

Status: 2023

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Minimal Credentialing in Post-Acute and Long-Term Care (PALTC) Medicine

Policy Statement

The American Osteopathic Association (AOA) support laws and/or policies to require employers in the post-acute and long term care (PALTC) arena to obtain at a minimum, proof of identification, i.e., a current government issued photo identification (e.g., driver's license), a current state issued professional license, and, as appropriate, malpractice insurance certificate and a current DEA certificate for all healthcare providers before allowing them to provide care in their facilities.

Source: H629-A/23

Status: 2023

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Requirement for Minimum Education Standards for Medical Directors

Policy Statement

The American Osteopathic Association (AOA) support minimum education standards for physicians serving in the role of Medical Director in Post-Acute and Long-Term Care.

Source: H630-A/23

Status: 2023

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Non-Compete Clauses in Healthcare Employment Contracts

Policy Statement

The American Osteopathic Association (AOA) opposes the use of those non-compete clauses that can hinder fair market competition. The AOA supports policies seeking to reform the use of non-compete clauses to ensure that they are used in a manner that does not harm patient care or place an unreasonable burden on physicians' ability to practice medicine.

Source: H633-A/23

Status: 2023

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Cooperation of the Veterans Administration and Non-VA Clinicians

Policy Statement

The American Osteopathic Association (AOA) supports the development and implementation of methodology for the efficient and secure sharing of the data in patient records between all VA and Non-VA clinicians.

Source: H600-A/24

Status: 2019; 2024 Adopted

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Addressing the Gender Pay Gap in the Medical Profession

Policy Statement

The American Osteopathic Association (AOA) acknowledges the existence of the "gender pay gap" between male and female physicians in the United States.

The AOA shall support the adoption of policies and practices that ensure the equitable compensation of physicians who work the same job regardless of gender.

Source: H601-A/24

Status: 2019; 2024 Adopted

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Investment Tax

Policy Statement

The American Osteopathic Association (AOA) notes that it is the responsibility of all osteopathic associations with 501{c}(6) tax status to urge their state legislators, U.S. senators and representatives, to defeat any proposed expansion of the tax on unrelated business income to include dividends, capital gains and/or interest income on reserves and current operational funds, under the 501{c}(6) tax status.

Source: H602-A/24

Status: 1999; 2004 Reaffirmed; 2009 Reaffirmed as Amended; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted

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Family Medical Leave Act Employee Relationship Modification

Policy Statement

The American Osteopathic Association (AOA) supports legislation amending the Family Medical Leave Act (FMLA) Basic Leave Entitlement ‘to care for the employee’s spouse, son or daughter, or parent, who has a serious health condition’ to include responsible designee; and requests the Department of Labor to include these changes at the federal level.

Source: H603-A/24

Status: 2009; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted

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Industry Transparency Standards

Policy Statement

The American Osteopathic Association (AOA) acknowledges the contributions made by pharmaceuticals, biologics, and medical devices to the improved health, management of disease, and enhanced life function for millions of patients cared for by physicians.

Source: H604-A/24

Status: 2009; 2014 Reaffirmed as Amended; 2019 Reaffirmed as Amended; 2024 Adopted as Amended

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OMT – Osteopathic Manipulative Treatment

Policy Statement

The American Osteopathic Association (AOA) urges that in all forms of communication the term OMT shall always be “Osteopathic Manipulative Treatment.”

Source: H605-A/24

Status: 1999; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted

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Drug Therapy Surveyor Guidelines for Nursing Homes

Policy Statement

The American Osteopathic Association (AOA) supports drug therapy surveyor guidelines regarding inappropriate drug use in nursing facilities be developed in collaboration with professional organizations possessing clinical expertise in geriatrics and long-term care medicine.

Source: H606-A/24

Status: 1999; 2004 Reaffirmed as Amended; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Adopted

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Beer's Criteria for Potentially Inappropriate Medication Use in Older Adults - Use Of

Policy Statement

The American Osteopathic Association (AOA) recognizes the limitations of the Beer's Criteria, as published by the American Geriatrics Society, as guidelines and not mandates to limit or prohibit access to medications deemed appropriate by the patient’s physician.

Source: H607-A/24

Status: 2014; 2019 Reaffirmed as Amended; 2024 Adopted

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Latex Allergy

Policy Statement

The American Osteopathic Association (AOA) strongly encourages hospitals and other healthcare facilities to provide non-latex alternatives.

Source: H608-A/24

Status: 1999; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed

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Pharmaceutical Packaging/ Environmental Responsibility

Policy Statement

The American Osteopathic Association (AOA) supports environmentally responsible packaging of pharmaceutical samples.

Source: H609-A/24

Status: 1991, 1994 Reaffirmed; 1999 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted

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Standing Against Restrictive Housing and Solitary Confinement for Juvenile Inmates of Prison Systems in the U.S.

Policy Statement

The American Osteopathic Association (AOA) will follow the recommendations outlined in the White Paper.

Opposing Restrictive Housing and Solitary Confinement for Juvenile Inmates of Prison Systems in the U.S.

Introduction

Every day an alarming number of youth under the age of 18 are placed in correctional facilities as a result of juvenile or criminal justice involvement.[1] Correctional facilities generally offer limited medical and mental health care, resulting in harmful health outcomes, such as increased violence, mental illness, cognitive impairment, and increased risk of disease. It is not uncommon for incarcerated youth to be housed in solitary confinement or restrictive housing while in these facilities. The use of solitary confinement further compromises the quality of the health care detainees receive, and results in long-lasting, adverse physical, psychological, and social effects. Thus, the use of such housing has become a major public health concern in the U.S.

For many individuals who are committed to improving health outcomes for juvenile youth, there has been an urgent need for interventions and reformation programs that encourage humane alternatives and movement towards the abolishment of juvenile solitary confinement in the U.S. In fact, several professional and human rights organizations have taken positions in favor of limiting or eliminating solitary confinement.

The purpose of this paper is to discuss the frequency and impact of solitary confinement (isolation) on juvenile well-being and to present the AOA's position opposing restrictive housing and solitary confinement for juvenile inmates in the U.S.

Solitary Confinement

The term, solitary confinement, is often used interchangeably with the terms segregation, isolation, and restrictive housing. The National Commission on Correctional Health Care refers to solitary confinement, or isolation, as the housing of an adult or juvenile with minimal to rare meaningful contact with other individuals. Additionally, the United States Department of Justice defines restrictive housing as any type of detention that involves one of the following:[2]

1. Removal from the general inmate population, whether voluntary or involuntary.
2. Placement in a locked room or cell, whether alone or with another inmate.
3. Inability to leave the room or cell for the vast majority of the day, typically 22 hours or more.

There are several forms of restrictive housing. High security facilities that contain solitary confinement units are called supermaximum ("supermax") facilities.[3] These facilities house inmates who have engaged in violent behavior aimed at other inmates or staff in another institution or those who were not compliant at lower-security prisons. Some supermax facilities also house inmates in protective custody or those considered to be a "special population", such as prisoners on death row. In addition to these facilities, there are facilities that contain solitary confinement cells, known as segregated housing or secured housing units, in institutions that are not considered supermax facilities.[3]

By design, solitary confinement restricts human contact and environmental simulation. The facilities commonly have minimal natural light, leaving detainees exposed to constant artificial light, and inmates experience punitively distasteful meals, have limited personal items, and are denied opportunities to communicate with others.[3]

Public Health Implications

Though data on the frequency and duration of solitary confinement is scant, the Office of Juvenile Justice and Delinquency Prevention reports that half of the individuals in the juvenile penal system were isolated for more than four hours at a time.[4] Exact statistics are not readily available, since the federal government does not require prisons to report the number of juveniles in solitary confinement, the frequency, or the amount of time they are isolated.[3]

In some jurisdictions, youth may be detained in solitary confinement for several weeks or months. In addition to the harms associated with adults in solitary confinement, youth may also lack educational options or interaction with their families, and they may experience the beginning of mental illnesses that commonly occur during late adolescence.[5]

Many studies have underscored the troubling realities of physical and mental health outcomes directly related to the increase of solitary confinement. While incarceration alone yields unintentional but inevitable consequences on wellness, especially mental health issues, solitary confinement amplifies the risk of anxiety, depression, psychosis and self-harm, as supported by both the American Psychological Association and American Academy of Child and Adolescent Psychiatry.[6]

The practice of placing youth in solitary confinement is especially troubling since children and young adults are still developing physically, mentally, and socially and are more vulnerable to the noted long-lasting negative effects of solitary confinement. Accordingly, mental health problems are more prevalent among youth inmates compared to adult inmates, with 95% of youth in the juvenile penal system having at least one mental health problem, and 80% of youth developing more than one mental health illness.[7]

Furthermore, the Centers for Disease Control and Prevention reports that in 2021, suicide was the 2nd leading cause of death for people aged 10-14 and 20-34.[8] However, young people in prisons are 18 times more likely to commit suicide than their counterparts in the community.[7] Thus, isolation of juveniles increases the risk of both mental illness and suicide for adolescents and young adults. Thus, concerns about the use of solitary confinement have mounted.

In a July 14, 2015 speech at the NAACP National Convention, President Barack Obama announced that he had asked Attorney General Loretta Lynch to conduct a review of "the overuse of solitary confinement across American prisons." The President directed that the focus

not only on understanding how, when, and why correctional facilities isolate certain prisoners from the general inmate population, but also that it includes strategies for reducing the use of this practice throughout our nation's criminal justice system.

Among other findings, the study report summary noted that the implementation of solitary confinement and the length of time an inmate is isolated is the discretion of correctional officers, not decided by a court or jury. The report also recommended that the Bureau end the practice of placing juveniles in restrictive housing, pursuant to the standards proposed in the Sentencing Reform and Corrections Act of 2015.[2]

The United Nations has also taken a stance against solitary confinement and considers isolation within juvenile facilities a form of torture. The U.N. has encouraged the U.S. to create federal and state legislature ratifying the Convention on the Rights of the Child, an international agreement set forth by the U.N. to protect children from abuse. To date, only seven U.S. states have placed any prohibition on juvenile solitary confinement.[3]

The American Academy of Child and Adolescent Psychiatry highlights the code of ethics surrounding the psychiatrist's responsibility to not only reduce the harmful impacts of the behavior of others but the community and social effects as well.[7] Often, correctional facilities have a culture of their own that produces a different code of ethics for the survival and safety of juvenile inmates; this can create a dilemma for clinicians as it relates to providing quality care to inmates.

Within the issue of solitary confinement in juvenile detention facilities, there is a concern that certain races/ethnicities are disproportionally exposed to these practices than youth from other races/ethnicities.

Social and Societal Impact

Isolation due to incarceration creates separation from society that makes it very difficult to form a social identity. Solitary confinement exacerbates the social complexities and behaviors of re-entering into society by aggravating preexisting depression or anxiety due to separation from home or the community. Consequently, isolation hinders the development of juveniles, making it extremely difficult for them to reintegrate into the community easily or productively.[3]

Additionally, author, Jessica Lee, highlights that solitary confinement also negatively impacts the physical growth of juveniles by restricting much needed exercise and nutrition.[3]

Reformation Efforts

The impact of juvenile solitary confinement has led to a call for reform by legislators and scientific scholars.[3] Although some states have been successful in abolishing or reducing solitary confinement, it is still practiced within the juvenile penal system.[4] This call for reform regarding solitary confinement has the potential to shift the juvenile justice system toward a more ethical and just model.

- **Federal Reformation Efforts**

U.S. Representative Cedric Richmond presented a bill calling for a study across the nation on the impacts that solitary confinement has on mental health. The intent of this bill, known as the Solitary Confinement Study and Reform Act of 2014, was to reduce the use of solitary confinement.[3] The bill died and was reintroduced to the House in 2015.

In 2015, Senator Cory Booker introduced “Maintaining Dignity and Eliminating Unnecessary Restrictive Confinement of Youth”, commonly known as the Mercy Act. The Mercy Act entails the following:

1. Prohibits the use of solitary confinement of juveniles in federal custody, except for a maximum of three hours, if the juvenile harms any individual.
2. Requires that facilities first use less restrictive measures to control behavior before placing the juvenile into solitary.
3. If, after the maximum three hours of solitary have ended, the juvenile still poses a risk of physical harm to themselves or anyone else, then the juvenile can be transferred to a different juvenile facility or “internal location” where he or she can be treated without the use of solitary.

The Mercy Act was introduced to the Senate in 2017, but no further action has been taken.[3]

- **State & Local Reformation Efforts**

In the state of New York, legislators agreed to ban solitary confinement for inmates younger than 21 at Riker’s Island and implement a practice where inmates between the ages of 18-21 undergo counseling and classes in a different facility as an alternative.[3] The reason for this reform was to combat the psychological effects that solitary confinement has on young adults and youth. Other states have joined in on State and Local reformation with varying approaches to the public health issue. For instance, in Pennsylvania mentally ill inmates will no longer be placed in solitary confinement; instead, they will be placed in special treatment units.

Although these laws are progressive, they do not address all of the concerns about solitary confinement among youth. There has been a huge push by activists and researchers for Congress and the U.S. Department of Justice to bring forth uniformity across the nation’s legislation to provide a standard and just approach to juvenile inmates regarding solitary confinement in the U.S. prison system. [9]

- **Educational Efforts**

Many medical and research organizations, such as the National Alliance for Suicide Prevention, have developed recommendations and interventions for “improving the level and quality of collaboration between the juvenile and mental health systems, primarily for suicide prevention.” [10] These collaborative efforts are tailored to promoting education, awareness, and prevention support and services for youth in the juvenile prison system. In these educational programs, organizations and researchers identify protective factors to decrease mental illness and suicide. In so doing, many organizations also are promoting data collection and inmate screening/assessment tools to increase information on solitary confinement in an effort to better understand and combat the psychological and social impacts of solitary confinement. More information and knowledge will allow health care professionals and public health practitioners to monitor the social development and health outcomes for inmates in juvenile facilities.[11]

Opposition To Reformation Efforts

Despite evidence of deleterious effects of solitary confinement in the juvenile penal system, there is still some opposition to reformation efforts. Opponents suggest that solitary confinement serves pragmatic purposes. For example, when prisons are overloaded with inmates, there is no physical space for them, or enough staff to run the prison. In this instance, solitary confinement provides additional housing space for inmates.[12] Others contend that solitary

confinement aids in the rehabilitation of character as it becomes a means of reflection for inmates. Another viewpoint is that solitary confinement offers prison safety for inmates who are a threat to staff, other inmates, or the public.[11] Finally, some believe that solitary confinement provides guards/officers with the means to discipline and maintain order within the prison walls.[11]

Conclusion

Nearly half of juveniles placed in the U.S. Prison system experience solitary confinement. As a result, the majority of these juveniles also have detrimental, long-lasting, physical and psychological health outcomes. Education, counseling, and rehab programs are all positive alternatives to solitary confinement that raises health outcomes for youth. Increased State and Federal legislation that actively opposes juvenile solitary confinement will not only positively impact youth outcomes but society as well when inmates reintegrate into their communities. Opposing solitary confinement and restrictive housing would be a significant step forward in saving lives and improving health and well-being outcomes.

American Osteopathic Association Policy

Given the research surrounding the negative impacts of restrictive housing and solitary confinement, the American Osteopathic Association adopts the following policy statements as its official position on opposing restrictive housing and solitary confinement for juvenile inmates of the prison system in the U.S.:

1. The official position of the American Osteopathic Association (AOA) is that youth incarceration is meant to be rehabilitation and that the use of juvenile solitary confinement and/or restrictive housing imparts serious psychological and physical harm.
2. The American Osteopathic Association encourages increased research and data collection surrounding the prevalence of the use of solitary confinement /restrictive housing among juveniles.

3. The American Osteopathic Association opposes the use of solitary confinement and/or restrictive housing among juveniles in the penal system and supports the abolishment of the use of solitary confinement and isolation for incarcerated youth set forth at the United Nations Convention on the Rights of the Child.

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Source: H610-A/24

Status: 2019; 2024 Adopted as Amended

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Third-Party Payors and Utilization Review Firms – Accountability

Policy Statement

The American Osteopathic Association (AOA) supports the disclosure of the origin of utilization review criteria used by payor and will advocate to ensure that utilization management criteria are evidence-based and developed with publicly available evidence. The AOA opposes the use of criteria or algorithms that rely on proprietary information held by the plan that cannot be researched or externally validated.

Source: H611-A/24

Status: 1994; 1999 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted as Amended

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Local Coverage Determination

Policy Statement

The American Osteopathic Association (AOA) encourages public and private insurance carriers, as well as the Centers for Medicare and Medicaid Services to utilize the local coverage determination (LCD) adopted in the State of Florida as a guide when determining coverage requirements for osteopathic manipulative treatment.

Source: H612-A/24

Status: 2009; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted

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Mergers and Buy-Outs of Third-Party Payors

Policy Statement

The American Osteopathic Association (AOA) advocates that all third-party payors automatically enrolling physicians in all products of an acquiring company should notify the physician of the products offered and permit physicians to reject one or all of the products of the acquiring company.

Source: H613-A/24

Status: 2004; 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Adopted

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Federal Health Information Technology Initiatives - AOA Support

Policy Statement

The American Osteopathic Association (AOA) advocates for federal Health Information Technology (HIT) initiatives seeking to promote interoperability and data exchange by assisting its members through education and other services necessary for them to adopt the appropriate technology which would be cost effective for their practices. The AOA also supports federal efforts to help physician practices make investments in technical infrastructure that better enables their participation in value-based care and quality initiatives.

Source: H614-A/24

Status: 2009 Reaffirmed; 2014 Reaffirmed as Amended; 2019 Reaffirmed; 2024 Adopted as Amended

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Electronic Health Records Software – Reporting Errors to Physicians

Policy Statement

The American Osteopathic Association (AOA) supports prompt notification by Electronic Health Record (EHR) vendors to physician clients of reported software errors and provisions of software updates that correct these errors, in a systematic, fashion as soon as possible at no cost to the EHR end user.

Source: H615-A/24

Status: 2014; 2019 Reaffirmed as Amended; 2024 Adopted as Amended

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Government Intervention in Private Practice

Policy Statement

The American Osteopathic Association (AOA) strongly recommends that any intervention by federal, state or private third-party payers shall not impose a financial penalty on any physician without proper peer review and opportunity for appeal, and encourages the continued availability of judicial review of claims.

Source: H616-A/24

Status: 1985; 1990 Reaffirmed; 1994 Reaffirmed; 1999 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed as Amended; 2024 Adopted

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Patient Matching of Electronic Health Record Data

Policy Statement

The American Osteopathic Association (AOA) in will follow the recommendations outlined in the White Paper.

Policy Brief on Patient Matching

Overview:

As patient electronic health information can be more easily shared between physicians, health information exchanges, and payers, patient identification (patient matching) remains a persistent problem in ensuring that electronic health record (EHR) data is complete and accurate. According to a 2019 national survey, 20% of providers and health information exchanges reported that more than 10% of their stored records are duplicates, with some respondents reporting more than 50% duplication in their records[1]. These high duplication and mismatch rates often translate into unnecessary resource use and poor outcomes when patient records are not up-to-date or contain inaccurate information**.** The same study found that about 38% of healthcare providers experienced an adverse event in the last two years because of patient matching issues. additionally, 45% of large hospitals reported difficulty matching or identifying the correct patients between systems[2]

Robust and accurate information exchange is central to delivering high quality, cost effective care. Although it requires significant investment, improving patient matching rates will provide benefits to the greater healthcare system that extend far beyond individual encounters.

The office of the national coordinator (ONC) published the trusted exchange framework, a common set of principles designed to increase trust across health information networks, in 2022 to support improved data sharing across healthcare entities. These principles, combined with the common agreement, a legal contract for defining technical requirements for participation, (known together as TEFCA), were developed with the goal of simplifying connectivity to securely exchange information to improve patient care. These nationwide exchange efforts make the need for effective record matching especially important.

Being able to effectively capture, track, and share data relating to patients' social determinants of health is crucial to delivering high-value care management and promoting well-being outside of a hospital. Not only would accurate capture and sharing of patient data promote better care coordination once a patient is back in their community, but it also supports better population level analytics.[3] Despite the need to improve patient matching, no clear standards for patient matching exist, and there are numerous legal and operational barriers to driving standardization across the healthcare landscape.

Past and Current Proposals

Policy efforts to improve the matching of patient records in an increasingly digital health care system date back to the mid-1990s. As part of the Health Information Portability and

Accountability Act (HIPAA) in 1996, Congress directed the Department of Health and Human Services (HHS) to develop a unique identifier for each individual, employer, provider, and plan within the US healthcare system. However, following the passage of HIPAA, there was significant pushback against this provision due to privacy and security concerns. As a result, Congress walked back the proposal by inserting language into appropriations bills that prohibited HHS from using federal funds to develop unique patient identifiers (UPIs) for individuals.

As the number of digital patient records across the US health care system proliferates, it is becoming increasingly important that providers can de-duplicate records and effectively match them to the proper patient. In response to public comments describing "patient address" as a useful data element for accurate patient matching in lieu of a UPI, ONC collaborated with standards development organizations to create project us@, an initiative intended to establish consistent patient address formatting to support patient matching by issuing a unified technical specification for health records. researchers estimate that formatting addresses according to the U.S. postal service specifications will aid in more accurately linking records[4]. "Patient address" and "patient former address" are included as data elements in the united states core data for interoperability (USCDI) as a standard, finalized in 2020. While this effort is important to support patient matching, additional demographic data is necessary to effectively match patient records. certain individuals, including unhoused individuals, would be negatively impacted by efforts that rely exclusively on addresses.

Without a UPI, the use of social security numbers could also help match records, along with other data elements. A study published in Perspectives in Health Information Management asserts that creating a field for at least the last 4 digits of a patient's social security number, and capturing a patient's full middle name, would increase match accuracy substantially.[5]

Challenges of Each Approach

While there is a great amount of discussion around national standards for patient demographic data and the need for additional identifying information, there is disagreement on whether it would be more appropriate to encourage the use of social security numbers or to seek legislative action to create unique patient identifiers.

Inclusion of social security numbers in patient records would improve patient matching, and standards that require fields for social security numbers in EHRs would not require legislative action. However, various challenges exist to achieving widespread adoption of this practice. First, individuals are often reluctant to provide SSNs out of concern for identity theft. Under this approach, patients would likely have various records with different providers containing their SSNs, increasing their exposure to identity theft risk. Although this perceived risk may be marginal, the fear is likely to be a deterrent to patients offering this information. Second, many states outlaw the collection of social security numbers for health care purposes, and a federal standard that included SSN collection would not apply in these states. Third, as a result of federal legislation, Medicare now provides patients with Medicare cards to shift away from having patients provide social security numbers. Alternatively, the use of Medicare cards can improve patient matching for this particular population.[6]

As an alternative to social security numbers, various groups have proposed using different unique patient identifiers, including numbers that would be issued by CMS, encouraging the use of biometrics as an additional authenticator, or incorporating additional personal authenticators within patient records that patients would then confirm (personal questions or text message authentication). However, these changes would be costly to implement and there is no consensus on what approach would be best.

Position of the AOA

In light of the current debate regarding the most effective way to match patient data that does not present privacy and security risks, the AOA supports efforts to develop national standards with appropriate safe guards for authentication, and collection of patient demographic data. In order to make the sharing of patient data more efficient and accurate, all health care organizations must collect the same information and enter it in a standardized format. The AOA will support policies that will achieve standardization of identifying data in patient records.

Additionally, because patient health data is particularly sensitive information and patient records contain large amounts of identifying information, the AOA will support the strengthening of privacy and security standards for the certification of EHRs and application programming interfaces.

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Source: H617-A/24

Status: 2019; 2024 Adopted as Amended

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Centers For Medicare and Medicaid Communications with Physicians

Policy Statement

The American Osteopathic Association (AOA) supports the distribution of thorough and current written information by all Medicare administrative contractors on the correct preparation and coding of Medicare claims to all physicians and supports communication to the physician of the complete justification for the denial of any Medicare claims.

Source: H618-A/24

Status: 1999; 2004 Reaffirmed; 2009 Reaffirmed as Amended; 2014 Reaffirmed; 2019 Reaffirmed; 2024 Adopted

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Mandated Patient Care – Assignment of

Policy Statement

The American Osteopathic Association (AOA) strongly opposes any attempt by a workman's compensation payer, or any other third-party payor, business, institution or government to mandate a patient be seen and managed by any individual, in any setting without the timely notification of and concurrence of the patient's physician and the informed consent of the patient.

Source: H619-A/24

Status: 1999; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed as Amended; 2024 Adopted as Amended

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Hospice – Federal Reimbursement for Required Face-to-Face Visits

Policy Statement

The American Osteopathic Association (AOA) supports reasonable federal payment to hospice organizations for federally required face-to-face visits for patients enrolled in hospice.

Source: H620-A/24

Status: 2014; 2019 Reaffirmed as Amended; 2024 Adopted

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Palliative Care – Federal Funding for Support Services

Policy Statement

The American Osteopathic Association (AOA) supports federal funding for chaplain, social work, and home health aide provider services for palliative care patients.

Source: H621-A/24

Status: 2014; 2019 Reaffirmed; 2024 Adopted

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Regulation of Health Information Technology Software

Policy Statement

The American Osteopathic Association (AOA) supports a multi-stakeholder consensus-based process for developing and evaluating technical standards for health information technology (health it) and will work with the office of the national coordinator for health information technology on adoption of appropriate standards into its health IT certification program. Patient safety improvements in quality, effectiveness, and efficiency of care delivery should be paramount when developing certification criteria and policies surrounding health IT adoption and use. The AOA advocates for a framework for the nationwide exchange of data, in a manner that ensures privacy and security protections for patients' health information, for treatment, payment, healthcare operations, public health, individual access, and patient safety purposes. The AOA also supports a common data structure that will enable interoperability; setting a clear course of action, supporting an exchange infrastructure, and adopting standards that will make it easier to share information so that physicians and patients can make informed decisions.

Source: H622-A/24

Status: 2014; 2019 Reaffirmed; 2024 Adopted as Amended

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Emerging Affiliates-Assistance by Other and the AOA

Policy Statement

The American Osteopathic Association (AOA) encourages liaison between affiliate organizations whether formal or informal and supports assistance to affiliate organizations in need.

Source: H623-A/24

Status: 1979; 1984 Reaffirmed; 1989 Reaffirmed; 1994 Reaffirmed; 1999 Reaffirmed; 2004 Reaffirmed; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed as Amended; 2024 Adopted as Amended

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Mail Order Pharmacy

Policy Statement

The American Osteopathic Association (AOA) opposes pharmaceutical programs that require all medications be delivered to the patient's residence as failing to act in the best interests of the patient. Maintenance medication prescriptions should be obtainable by the means preferred by the patient.

Source: H624-A/24

Status: 2004; 2009 Reaffirmed; 2014 Reaffirmed; 2019 Reaffirmed as Amended; 2024 Adopted

AMERICAN OSTEOPATHIC ASSOCIATION

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Maintenance of Licensure

Policy Statement

The American Osteopathic Association (AOA) will follow the recommendations outlined in the White Paper.

The American Osteopathic Association (AOA):

(1) supports the development of state level maintenance of licensure (MOL) programs to demonstrate that all physicians are competent to provide quality care that incorporates relevant technological and scientific advancements over the course of their career. Flexible pathways for achieving MOL should be maintained. The requirements for MOL should balance transparency with privacy protection and not be overly burdensome or costly to physicians or state licensing boards.

(2) Continues to address and promote physician competency through the teaching of core competencies at the predoctoral and postdoctoral levels as well as ongoing physician assessment through Osteopathic Continuous Certification (OCC)

(3) Continues to work with State Osteopathic Affiliates, the American Association of Osteopathic Examiners and other stakeholders to establish and implement MOL policies that promote patient safety and the delivery of high quality of care.

(4) Through its bureaus, councils and committees, will continue to ensure that OCC is recognized by the federal government, state governments and other regulatory agencies and credentialing bodies as equivalent to other national certifying bodies' "maintenance" or "continuous" certification programs.

(5) While supporting the use of board certification as a recognition of quality and excellence, signifying the highest physician achievement in a particular specialty; opposes any efforts to require OCC as a condition of medical licensure;

(6) Collaborates with entities properly qualified for and tasked with decision-making regarding insurance payment, hospital privileges, network participation, malpractice insurance coverage, physician employment, to determine the role of physician board certification and OCC or other "maintenance of certification" programs in such decisions.

(7) Continues to innovate and improve the OCC process.

Source: H625-A/24

Status: 2010; 2015 Reaffirmed; 2017 Reaffirmed; 2019 Reaffirmed as Amended; 2024 Adopted

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Osteopathic Terminology - Glossary of

Policy Statement

The American Osteopathic Association (AOA) designates the entries in the Glossary of Osteopathic Terminology as the AOA's official terms and definitions; whenever terms or definitions in the Glossary of Osteopathic Terminology conflict substantively with AOA policy, AOA branding guidelines or AOA publications' style guidelines, the AOA will seek to resolve the conflict through the Glossary of Osteopathic Terminology's standard process for revision and external input; and the JOM -The Journal of Osteopathic Medicine's "Instructions for Authors" will advise authors to use the terms and definitions in the Glossary of Osteopathic Terminology.

Source: H626-A/24

Status: 2012; 2019 Reaffirmed; 2024 Adopted as Amended

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Taser Safety

Policy Statement

The American Osteopathic Association (AOA) encourages further research on cardiac arrest, death, and other adverse health effects associated with shocks from Conducted Electrical Weapons (CEW)

Source: H627-A/24

Status: 2008; 2013 Reaffirmed as Amended; 2018 Reaffirmed; 2023 Referred to BORPH; 2024 Adopted as Amended

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Physician Payment Adjustments for Budget Neutrality

Policy Statement

The American Osteopathic Association (AOA) will work with relevant stakeholders to reform budget neutrality such that all recipients of Medicare payment be treated equally with respect to cost containment strategies.

The AOA will work with relevant stakeholders to remediate the conversion factor to enhance physician payment to a level that is more reflective of the changes to overall Medicare spending since the 1989 budget neutrality provision became active.

The AOA will work with relevant stakeholders to ensure that the conversion factor be modified on an annual basis at a level no less than any increase to the Medicare economic index

Source: H628-A/24

Status: 2024 Adopted as Amended

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Approved Resolutions Status

Policy Statement

The American Osteopathic Association (AOA) provides twice yearly status updates to the AOA Past Resolutions webpage on the implementation and actions pertaining thereto on adopted resolutions within 30 days following the conclusion of the AOA Board of Trustees Midyear Meeting and within 30 days following the conclusion of OMED.

A suggested implementation would be on the existing AOA past resolutions webpage, add two more columns titled “interval update” and “annual update” with bullet list of undertaken actions with option for narrative explanation when appropriate.

Source: H631-A/24

Status: 2024 Adopted as Amended

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Prior Authorization Requirement for Osteopathic Manipulative Treatment

Policy Statement

The American Osteopathic Association (AOA) opposes a Prior Authorization requirement for Osteopathic Manipulative Treatment (OMT).

Source: H634-A/24

Status: 2024 Adopted as Amended