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.

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SUBJECT: H600-A/14 HOSPICE – FEDERAL REIMBURSEMENT FOR REQUIRED FACE-TO-FACE VISITS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

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

H600-A/14 HOSPICE – FEDERAL REIMBURSEMENT FOR REQUIRED FACE-TO-FACE VISITS

The American Osteopathic Association supports reasonable federal reimbursement payment to hospice organizations for federally required face-to-face visits for patients enrolled in hospice prior to the start of their third hospice benefit period. 2014

Explanatory Statement:

ACTION TAKEN _____________________

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

H601-A/14 PALLIATIVE CARE – FEDERAL FUNDING FOR SUPPORT SERVICES

The American Osteopathic Association supports federal funding for chaplain, social work and home health aide provider services for palliative care patients. 2014
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be SUNSET:

**H602-A/14 MEDICARE TRANSITION CARE CODES**

The American Osteopathic Association encourages the Centers for Medicare & Medicaid Services to simplify and clarify the rules for submission of Transition Care Codes. 2014

**Explanatory Statement:**
The BSA recommends to sunset H602-A/14. On March 17, 2016, CMS published a document titled “Frequently Asked Questions about Billing the Medicare Physician Fee Schedule for Transitional Care Management Services” that clarify rules for submission of these codes. The Transitional Care Management services were resurveyed in 2018. According to Medicare claims data, there has been increased use of these services, which indicates an understanding of the codes.


ACTION TAKEN _____________________

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

**H605-A/14 REGULATION OF HEALTH INFORMATION TECHNOLOGY SOFTWARE**

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 federal regulation of health software because it poses the lowest risk of potential harm and data should not 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, WHERE DATA CAN BE ACCESSED, ANALYZED, AND COMMUNICATED IN A TIMELY MANNER, which should be able to analyze data that can be communicated quickly. Existing programs should be leveraged and utilized. The AOA 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. 2014

Explanatory Statement:

**ACTION TAKEN _____________________**

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

H606-A/14 EMERGING STATES AFFILIATES – ASSISTANCE BY OTHER STATES AFFILIATES AND THE AOA

The American Osteopathic Association encourages liaison between state AFFILIATE organizations whether formal or informal and supports assistance to emerging state AFFILIATE organizations. 1979; revised 1984, 1989; reaffirmed 1994; revised 1999; reaffirmed 2004; 2009; 2014

Explanatory Statement:

ACTION TAKEN ____________________________

DATE ________________________________
RESOLVED, that the Bureau of Membership recommend that the following policy be
REAFFIRMED:

H607-A/12 OSTEOPATHIC TERMINOLOGY, GLOSSARY OF

The American Osteopathic Association 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 JAOA-The Journal of the American Osteopathic Association’s “Instructions for Authors” will advise authors to use the terms and definitions in the Glossary of Osteopathic Terminology. 2012

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H607-A/14 GOVERNMENT INTERVENTION IN PRIVATE PRACTICE

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

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

H607-A/14 GOVERNMENT INTERVENTION IN PRIVATE PRACTICE
The American Osteopathic Association strongly recommends that any intervention by FEDERAL OR PRIVATE third party payers (Medicare, Medicaid and other third party insurers), shall not IMPOSE A FINANCIAL PENALTY ON penalize any physician without proper peer review and opportunity for appeal, without prejudice or penalty, and encourages the continued availability of judicial review of claims of Part B Medicare and other third party payers. 1985; revised 1990, 1994; reaffirmed 1999; revised 2004; reaffirmed 2009; 2014

Explanatory Statement:

ACTION TAKEN _____________________

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

**H608-A/14 DRUG THERAPY SURVEYOR GUIDELINES FOR NURSING HOMES**

The American Osteopathic Association 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. 1999;
revised and reaffirmed 2004; reaffirmed 2009; reaffirmed as amended 2014

Explanatory Statement:

ACTION TAKEN _____________________

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

H609-A/14 CENTERS FOR MEDICARE AND MEDICAID (CMS) COMMUNICATIONS WITH PHYSICIANS

The American Osteopathic Association 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 reasons JUSTIFICATION for the rejection DENIAL of any Medicare claims be communicated to the physician. 1999; revised 2004; reaffirmed as amended 2009; reaffirmed 2014

Explanatory Statement:

ACTION TAKEN _____________________

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

**H610-A/14 MANDATED PATIENT CARE – ASSIGNMENT OF**

The American Osteopathic Association strongly opposes any attempt by a third-party payer, business, institution or government to mandate a patient be seen and managed by any individual, including a hospitalist, or anyone other than the patient’s physician in any setting without the concurrence of the patient’s physician. 1999; revised 2004; reaffirmed 2009; 2014

Explanatory Statement:

ACTION TAKEN _____________________

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

**H611-A/14 INVESTMENT TAX**

The American Osteopathic Association 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 congressmen, 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. 1999; revised 2004; reaffirmed as amended 2009; reaffirmed 2014

**Explanatory Statement:**

**ACTION TAKEN _____________________**

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

H613-A/14  OMT – OSTEOPATHIC MANIPULATIVE TREATMENT
The American Osteopathic Association urges that in all forms of communication the term
OMT shall always be “Osteopathic Manipulative Treatment.” 1999; revised 2004; reaffirmed
2009; 2014

Explanatory Statement:

ACTION TAKEN ______________________________

DATE ______________________________
SUBJECT: H614-A/14 THIRD-PARTY PAYERS AND UTILIZATION REVIEW FIRMS – ACCOUNTABILITY

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

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

H614-A/14 THIRD-PARTY PAYERS AND UTILIZATION REVIEW FIRMS – ACCOUNTABILITY

The American Osteopathic Association supports the disclosure of the origin of utilization review criteria used by third-party payers. 1994; revised 1999, 2004; reaffirmed 2009; 2014

Explanatory Statement:

ACTION TAKEN ______________________________

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

**H615-A/14 MAIL ORDER PHARMACY**

The American Osteopathic Association 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; and that maintenance medication prescriptions may SHOULD be obtainable at a pharmacy at the patient’s discretion. 2004; reaffirmed 2009; 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be SUNSET:

H617-A/14 MEDICARE PHYSICIAN PAYMENT

The American Osteopathic Association will work with the Centers for Medicare and Medicaid Services (CMS), Congressional Committees of jurisdiction and the Medicare Payment Advisory Commission (MedPAC) to reform the Medicare physician reimbursement formula to protect and enhance the ability of osteopathic physicians to provide quality care and protect Medicare beneficiaries access to physician services; and will identify and aggressively pursue the enactment of long-term remedies to the sustainable growth rate (SGR) formula that protect and maintains quality patient care. 2004; reaffirmed as amended 2009; reaffirmed 2014

Explanatory Statement:
The BSA recommends to sunset. In April 2015, the Medicare Sustainable Growth Rate (SGR) formula for physician payment was permanently repealed and replaced by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

ACTION TAKEN _____________________

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

H618-A/14 MERGERS AND BUY-OUTS OF THIRD PARTY PAYERS

The American Osteopathic Association advocates that all third party payers 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. 2004; 2009; reaffirmed as amended 2014

Explanatory Statement:

ACTION TAKEN _______________________

DATE ______________________________

SUBJECT: H618-A/14 MERGERS AND BUY-OUTS OF THIRD PARTY PAYERS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED:

H619-A/14  FEDERAL HEALTH INFORMATION TECHNOLOGY INCENTIVES – AOA SUPPORT

The American Osteopathic Association supports the federal Health Information Technology (HIT) initiatives 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.

2009; reaffirmed as amended 2014

Explanatory Statement:

ACTION TAKEN _____________________

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

**H622-A/14 LOCAL COVERAGE DETERMINATION**

The American Osteopathic Association 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. [Editor’s note: All Medicare Local Coverage Determination (LCD) policies are accessible via the Internet at [http://www.cms.hhs.gov/DeterminationProcess/04_LCDs.asp](http://www.cms.hhs.gov/DeterminationProcess/04_LCDs.asp). 2009; reaffirmed 2014

**Explanatory Statement:**

ACTION TAKEN _____________________

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

**H623-A/14 LATEX ALLERGY**

The American Osteopathic Association strongly encourages hospitals and other healthcare facilities to provide non-latex alternatives. 1999; revised 2004; reaffirmed 2009; reaffirmed as amended 2014

Explanatory Statement:

ACTION TAKEN _________________________

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

**H624-A/14 MANAGED CARE PLANS – SERVICE, ACCESS AND COSTS IN**

The American Osteopathic Association supports efforts to combine tiered formulary and open access models with expanded use of variable co-pays that reflect the total costs of these programs and supports efforts to design benefits that align consumer needs and accountability and individual physician incentives. 1999; revised 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

Explanatory Statement:

ACTION TAKEN _________________________

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

H625-A/14 FAMILY MEDICAL LEAVE ACT (FMLA) EMPLOYEE RELATIONSHIP MODIFICATION

The American Osteopathic Association 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. 2009; reaffirmed 2014

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H626-A/14 PHARMACEUTICAL PACKAGING/ ENVIRONMENTAL RESPONSIBILITY

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

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

H626-A/14 PHARMACEUTICAL PACKAGING/ ENVIRONMENTAL RESPONSIBILITY


Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: 

H627-A/14 INDUSTRY TRANSPARENCY STANDARDS

SUBMITTED BY: 
Bureau on Federal Health Programs

REFERRED TO: 
Ad Hoc Committee

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

H627-A/14 INDUSTRY TRANSPARENCY STANDARDS

The American Osteopathic Association AOA: (1) 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 osteopathic physicians; (2) acknowledges concerns regarding the perception that pharmaceutical and device companies have undue influence over physicians; (3) affirms its commitment to providing all osteopathic physicians, their patients, and the public timely, accurate, and relevant information on advances in medical science, treatment of disease, prevention, wellness, and other information that advances mental and physical health; (4) continues its commitment to life-long learning for all osteopathic physicians; (5) supports transparency in its industry partnerships by creating a public web site that discloses DISCLOSING all industry partnerships entered into to advance life-long learning; (6) will further advance transparency by encouraging all partners to disclose fully their relationship with the AOA and other organizations; (7) directs the Council on Continuing Medical Education to adopt and implement transparency standards; (8) discourages business practices that interfere with the patient-physician relationship, attempt to unduly influence the practice of medicine, or attempt to inappropriately persuade patients to seek services or products; and (10) stands resolute that our commitment to advancing medical science, quality health care, the treatment of disease, and transparency in our actions, along with the ethical code by which our members serve, are the principles by which we engage industry partners. 2009; reaffirmed as amended 2014

Explanatory Statement:

ACTION TAKEN _____________________

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

H630-A/14 ELECTRONIC HEALTH RECORDS SOFTWARE – REPORTING ERRORS TO PHYSICIANS

The American Osteopathic Association will request that ELECTRONIC HEALTH RECORD (EHR) vendors of electronic health records notify physician clients of reported software errors and PROVISIONS OF provide software updates THAT CORRECT THESE ERRORS, in a systematic, COST-EFFECTIVE and timely fashion as is standard in other industries that correct these errors to enhance patient safety. 2014

Explanatory Statement:

ACTION TAKEN ___________________

DATE ___________________________
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be SUNSET:

H631-A/14 ELECTRONIC MEDICAL RECORD/PROFESSIONAL CREDENTIALS – SIGNATURE FOR

The American Osteopathic Association (AOA) will work with Electronic Health Record (EHR) vendors and the Healthcare Information and Management Systems Society to change the commonly used designation on EHR signature lines from “ordering MD” to “ordering physician/provider”. The AOA encourages all certified EHR vendors to provide a mechanism so documenting professionals can appropriately designate their degree or other professional credential. 2014

Explanatory Statement:
The BSA recommends to sunset H631-A/14. The ONC has confirmed that requirements in the certification criteria for the 2014 and 2015 edition of certified electronic health record technology (CEHRT) are agnostic to any specific professional credential.

ACTION TAKEN _____________________

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

H635-A/14  BEER’S CRITERIA FOR POTENTIALLY INAPPROPRIATE MEDICATION USE IN OLDER ADULTS-USE OF
The American Osteopathic Association recognizes the limitations of the Beer's Criteria as published by the American Geriatrics Society, due to the limitations and intent of the criteria as a measure of physician quality of care. 2014

Explanatory Statement:

ACTION TAKEN _______________________

DATE ____________________________
RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED:

H637-A/14 PHYSICIAN TESTING PROCESS FOR UNLIMITED LICENSURE – COLLABORATION TO PROTECT THE INTEGRITY OF THE

The American Osteopathic Association will collaborate with the American Medical Association, the Scope of Practice Partnership and the Federation of State Medical Boards to ensure that the National Board of Medical Examiners maintains and preserves the integrity of the testing process used to license only physicians (DO / MD) for the unlimited practice of medicine. 2009; reaffirmed 2014

Explanatory Statement:
SUBJECT: H638-A/14 MAINTENANCE OF LICENSURE

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED; and, be it further;

RESOLVED, that policy number H227-A/17 be deleted:

H638-A/14 MAINTENANCE OF LICENSURE
The American Osteopathic Association (AOA) (1) supports the development of state level maintenance of licensure (MOL) programs to demonstrate that osteopathic 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) The AOA will continue 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) and the AOA Clinical Assessment Program (CAP) or its equivalent. (3) The AOA will continue 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) THE AOA, THROUGH ITS BUREAUS, COUNCILS AND COMMITTEES, WILL CONTINUE TO ENSURE THAT OCC IS COMPARABLE TO OTHER MAINTENANCE OF CERTIFICATION PROGRAMS SO IN TERMS OF QUALITY AND CONTENT THAT OCC CAN BE 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 THE AOA SUPPORTS THE USE OF BOARD CERTIFICATION AS A MARK OF QUALITY AND EXCELLENCE, SIGNIFYING THE HIGHEST PHYSICIAN ACHIEVEMENT IN A PARTICULAR SPECIALTY; THE AOA OPPOSES ANY EFFORTS TO REQUIRE OCC AS A CONDITION OF MEDICAL LICENSURE. (6) THE AOA DEFERS TO ENTITIES PROPERLY QUALIFIED FOR AND TASKED WITH DECISION-MAKING REGARDING INSURANCE REIMBURSEMENT, 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) THE AOA THROUGH THE BUREAU OF OSTEOPATHIC SPECIALISTS WILL CONTINUE TO REVIEW THE OCC PROCESS SO AS TO MAKE IT MORE MANAGEABLE AND ECONOMICALLY FEASIBLE. 2010; REVISED 2015; REVISED 2017. [See also H258-A/08]; approved as amended 2014.
Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
WHEREAS, sunset resolution H-636 - A/2018, titled “STANDING AGAINST
RESTRICTIVE HOUSING AND SOLITARY CONFINEMENT FOR JUVENILE
INMATES OF PRISON SYSTEMS IN THE US”, was referred to the Bureau on
Scientific Affairs and Public Health (BSAPH) to study the frequency and impact of
solitary confinement and isolation on juvenile well-being; now, therefore be it,

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the
attached white paper, titled, “OPPOSING RESTRICTIVE HOUSING AND
SOLITARY CONFINEMENT FOR JUVENILE INMATES OF PRISON SYSTEMS
IN THE U.S.”, be adopted:

Opposing Restrictive Housing and Solitary Confinement for Juvenile Inmates of Prison
Systems in the U.S.

Introduction
Every day approximately 53,000 youth under the age of 18 are sent to correctional facilities as a result
of juvenile or criminal justice involvement. 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:  

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. 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.

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.

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. 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.

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.

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.

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.

Furthermore, the Centers for Disease Control and Prevention reports that suicide is the 3rd leading cause of death for youth, resulting in approximately 4,600 deaths per year. However, young people in prisons are 18 times more likely to commit suicide than their counterparts in the community. 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 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. 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.

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. Often, correctional facilities have a culture of their own that produce 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.

**Racial and Gender Disparities**

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. Across the nation, the youth rate of incarceration is 152 per 100,000. However, the Black youth placement rate is nearly three times higher than the national rate at 433 per 100,000. Comparatively, the White youth placement rate is 86 per 100,000, nationally. According to the Department of Justice, Black youth are five times more likely to be detained compared to Whites. When examining the system further, Black males and Native American females are an over-represented population in the U.S. juvenile prison system. Currently, in the U.S., Black males under the age of 18 make up 14% of the total population; however, 43% of Black males under 18 years of age are in juvenile facilities. Nationally, Native Americans make up less than 1% of all youth, but 3% of Indian females are in juvenile facilities. Over the last decade, the racial disparity in youth placed in the juvenile penal system has increased by nearly 22%. As a result of disparities in the number of justice-involved juveniles, minority youth detainees are more likely to suffer severe psychological/mental health issues and live in restrictive facilities away from home. Black juveniles, specifically, are experiencing worse health outcomes, especially mental health outcomes, due to disparities in the juvenile penal system.

**Social and Societal Impact**

Family support and love are essential for the development of juveniles social identity. However, visits, phone calls, and sometimes even letters are prohibited during solitary confinement, creating additional separation between inmates, their families, and the outside world in general. 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.
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.10

• 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.”11 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.\textsuperscript{13}

**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.\textsuperscript{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.\textsuperscript{13} Finally, some believe that solitary confinement provides guards/officers with the means to discipline and maintain order within the prison walls.\textsuperscript{15}

**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 harms.
2. The American Osteopathic Association encourages increased research and data collection surrounding the prevalence of the use of solitary confinement /restrictive housing among juveniles.

**References**


Explanatory Statement:

ACTION TAKEN ________________________________

DATE ________________________________
WHEREAS, clinical data registries and qualified clinical data registries (QCDRs) are used to collect patient information on various diseases, conditions, exposures, or procedures; and data can be used for various purposes including quality improvement, clinical research, disease surveillance, and value-based reimbursement; and

WHEREAS, clinical data registries and QCDRs not only play an important role in improving population health, while also playing an increasingly important role in physician reimbursement through quality payment reporting programs; and

WHEREAS, approximately 53% of clinical data registries report using their data for quality measure development, 61% report using data for clinical decision support development, 39% report being qualified clinical data registries for MIPS reporting, and 17% of registries report that their data is used to help determine payment for health services; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports the development of clinical data registries to improve the quality of patient care, improve population health, and promote high-value care and, be it further

RESOLVED, that the AOA will support efforts to make reporting more simplified and efficient and expand participation in clinical data registries and Qualified Clinical Data Registries (QCDRs) for the benefit of population health. The AOA will advocate to ensure that (1) participation in clinical data registries and QCDRs does not place a substantial cost burden on physicians; (2) data is used to improve quality of care for patients; (3) registry data is not used to penalize physicians; (4) that measures developed for reporting through clinical data registries and QCDRs are developed in collaboration with physicians and specialty groups; and (5) that physicians play an integral role in the oversight of clinical data registries and QCDRs.

References

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: COMMUNICATION TECHNOLOGY-BASED AND REMOTE EVALUATION SERVICES

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, CMS finalized policy for new communication technology-based and remote evaluation services in the 2019 Physician Fee Schedule that will pay physicians, rural health clinics (RHCs) and federally qualified health centers (FQHCs) for virtual check-in appointments, remote evaluation of pre-recorded (store and forward) patient information, and telephone or internet consultations services furnished using communication technology; and

WHEREAS, the new policy will allow payment to physicians, RHCs and FQHCs for use of telecommunication technology and are not meant to substitute for in-person services;

WHEREAS, the new communication technology-based and remote evaluation services are distinct from Medicare telehealth services as set forth in section 1834(m) of the Social Security Act and are not subject to the same statutory requirements; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) will work to ensure that the use of new communication technology-based and remote evaluation services, which resemble other Medicare telehealth and remote monitoring services are paid at a rate consistent with the time and work involved for the physician.

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: INCIDENT TO BILLING BY PHYSICIAN ASSISTANTS AND ADVANCE PRACTICE REGISTERED NURSES

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, the American Osteopathic Association advocates to preserve the physician-led, team-based model of care as the most effective approach to delivering high-quality care; and

WHEREAS, decreasing physician oversight of patient care can result in overutilization of diagnostic services, overprescribing of medications, unnecessary or inappropriate referrals, and ultimately poorer outcomes; and

WHEREAS, the Medicare Payment Advisory Commission has recently advised the Centers for Medicare & Medicaid Services to eliminate from federal regulation the provision allowing APRNs and PAs to bill “incident to” physician services has the potential to drive further scope of practice expansions; and

WHEREAS eliminating the “incident to” billing provision for APRNs and PAs may financially harm independent practices, as services billed by non-physicians practitioners under their own provider identification number are reimbursed at 85 percent of the Medicare physician fee schedule rate; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports maintaining the “incident to” billing provision for APRNs and PAs in order to preserve the physician-led, team-based model of care; and, be it further

RESOLVED, that the AOA will advocate to ensure that physicians who collaborate with advance practice registered nurses and physician assistants in their practices will continue to be able to earn full reimbursement for their collaborative efforts through “incident to” billing; and, be it further

RESOLVED, that the AOA will advocate to ensure that reimbursement for any APRN and PA services billed under the non-physician practitioner’s provider identification number will be reimbursed at an appropriate rate based on the provider’s background and training.

References
1. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1939374
Explanatory Statement:
The AOA does not have clear policy on the “incident to” billing provision or appropriate levels of reimbursement for APRNs and PAs by CMS.

ACTION TAKEN _____________________

DATE ______________________________
RES. NO. H-632 - A/2019 – Page 1

SUBJECT: PATIENT MATCHING OF ELECTRONIC HEALTH RECORD DATA

SUBMITTED BY: Bureau on Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, identification and duplication of patient records is a growing problem within the US electronic health record (EHR) ecosystem; and

WHEREAS, the mismatching of patient records can result in inadequate or inappropriate care that harms patient outcomes; and

WHEREAS, no national standards currently exist for patient matching; now, therefore be it

RESOLVED, that the American Osteopathic Association adopt the following policy paper on patient matching of EHRs:

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. Errors and missing information remain common in the electronic health record ecosystem, with approximately 8% of all records being split or duplicate. This error rate is higher (14% to 16%) within large health systems that store vast amounts of data for a large number of patients.1 When excluding matching within organizations to analyze patient matching rates between organizations, the match rate can drop to 50%.2 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. A 2016 report indicated that 4% of duplicate records result in negative clinical care and outcomes.

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. 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. As of March of 2019, as part of the HHS Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator’s (ONC) Proposed Rule on Interoperability and Information Blocking, HHS is proposing to improve patient matching by establishing standards for EHR developers regarding demographic data elements necessary within EHRs for patient matching. The rule also includes a request for information on what data elements would be useful in ensuring accurate patient matching and whether national standards for patient identification would be useful. Without a UPI, the most effective way to ensure accuracy of matched patient records is through the use of social security numbers. 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.4

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 and is actively shifting away from having patients provide social security numbers. Alternatively, the use of Medicare cards can improve patient matching for this particular population.5

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 safeguards 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.
References


Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: POST-PARTUM DEPRESSION (Response to RES. NO. H-612 - A/18 referencing H-615-A/13)

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

1 WHEREAS, the Ad Hoc Committee on July 21, 2018 referred H615-A/13 POSTPARTUM DEPRESSION to the Bureau on Scientific Affairs and Public Health to produce a report on outcomes; and

2 WHEREAS, the policy encourages American Osteopathic Association 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; now, therefore, be it

3 RESOLVED, that Bureau on Scientific Affairs and Public Health (BSAPH) receive additional time to collect the requested data from American Osteopathic Association’s internal sources as well external key stakeholders (e.g., COMS, osteopathic state and specialty associates); and, be it further

4 RESOLVED, that BSAPH develop and administer a survey to its external stakeholders to collect the requested information and provide a final report to the House of Delegates in July 2020.

ACTION TAKEN _____________________

DATE ______________________________
WHEREAS, there is always a need to improve the quality of healthcare worldwide; and

WHEREAS, this goal can be in part accomplished by sharing medical records between all Providers involved in patient care; and

WHEREAS, there is difficulty in sharing of Healthcare records between VA clinicians and Non-VA clinicians; and

WHEREAS, this failure to share records may cause unnecessary duplication of services in both systems which affects patient care; and

WHEREAS, in the Non-VA system there is an impact on the reporting of quality measures because of missing information or disinformation; and

WHEREAS, this missing information impacts the accuracy of HEDIS reporting as well as the overall status of complete healthcare received now; therefore be it

RESOLVED, that the leadership of the American Osteopathic Association coordinate with the leadership of the VA to expedite the development and implementation of methodology for the easy sharing of the data in patient records between all VA and Non-VA clinicians; and, be it further

RESOLVED, that both organizations work to ensure that the data be available to ALL interested third parties (CMS, ACOs, Insurance Companies, etc.) in an acceptable fashion for accurate data reporting regarding individual patients.

Explanatory Statement:

ACTION TAKEN _____________________

DATE ____________________________
SUBJECT: PRIOR AUTHORIZATION – PATIENT AUTHORIZATION

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, insurers, pharmacy benefit managers (PBMs), and third party administrators (TPAs), collectively Payors, continue to use the prior authorization (PA) to deny patients medically necessary medications; and

WHEREAS, one of the ways Payors accomplish this is to make the PA process more complicated and cumbersome than needed so as to discourage use of the PA process; and

WHEREAS, one of the techniques used by Payors to complicate the PA process is to require prescribers to obtain the patient's written permission to act as their agent in the PA process; and

WHEREAS, completing the PA process requires a significant knowledge of medicine and medication, a level of knowledge not usually possessed by the patient; and

WHEREAS, requiring a signed patient authorization to allow the physician to complete the PA process serves no purpose other than to delay or complicate the PA process; and

WHEREAS, one of the roles of a physician is to be an advocate for the patient within a complex healthcare system; now, therefore be it

RESOLVED, that the American Osteopathic Association advocate with insurers, pharmacy benefit managers (PBMs), third party administrators (TPAs), legislators and administrative agencies to allow the physician to complete the entire prior authorization process on behalf of the patient without the patient’s written authorization.

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
WHEREAS, obesity is a public health crisis which costs the US over $147 billion annually as of 2008 in lost productivity, medical care, morbidity and disability; and

WHEREAS, the prevalence of obesity was 39.8% and affected about 93.3 million of US adults in 2015~2016; and

WHEREAS, Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer that are some of the leading causes of preventable, premature death; and

WHEREAS, ensuring physician reimbursement for obesity treatment should be a priority to reduce morbidity and mortality of the population; and

WHEREAS, it is well within the scope of practice of ALL primary care physicians to treat this condition and obesity is not currently a payable diagnosis for primary care; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) publicly affirms and advocates that all diagnosis codes for obesity and morbid obesity be a billable and reimbursable diagnostic code for any and all practicing primary care physicians; and, be it further

RESOLVED, that the AOA work with insurers, payors, legislators, and other stakeholders to ensure access to treatment for obesity to address this public health epidemic.

References

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
WHEREAS, according to an American Medical Association (AMA) survey, more than 90% of physicians said prior authorizations including, but not limited to, prescriptions, procedures and durable medical equipment, had a significant negative clinical impact, with 28 percent reporting that prior authorizations had led to a serious adverse event such as a death, hospitalization, disability, permanent bodily damage, or another life-threatening event for a patient in their care;¹ and

WHEREAS, the vast majority of physicians (86 percent) described the administrative burden associated with prior authorization as “high or extremely high,” and 88 percent said the burden has gone up in the last five years; and

WHEREAS, 66% of prescriptions that get rejected at the pharmacy require a prior authorization, only 29% of patients end up with the original prescribed medication and 40% of patients end up abandoning the treatment altogether; and

WHEREAS, formulary changes are made indiscriminately and capriciously without notification to prescribers or patients and insurance enrollment periods are limited but policy and formulary changes by insurers can be made at any time; and

WHEREAS, nonmedical switching, when patients are switched to an alternative drug because the drug was removed from the formulary, worsened outcomes for 95% of chronic disease patients; now, therefore be it,

RESOLVED, that the American Osteopathic Association (AOA) adopt the following policy statement and affirm its tenets as a priority for advocacy:

The American Osteopathic Association (AOA) asserts that physicians using appropriate clinical knowledge, training, and experience should be able to prescribe and/or order without being subjected to the need to obtain prior authorizations. The AOA further maintains that a physician's attestation of clinical diagnosis or order should be sufficient documentation of medical necessity for durable medical equipment. In rare circumstances when prior authorizations are clinically relevant, the AOA upholds they should be evidenced-based, transparent, and efficient to ensure timely access and ideal patient outcomes. Additionally, physicians that contract with health plans to participate in a financial risk-sharing agreement should be exempt from prior authorizations.

The AOA affirms that prior authorizations should be standardized and universally electronic throughout the industry to promote uniformity and reduce administrative burdens. Prior authorizations create significant barriers for physicians to deliver timely
and evidenced-based care to patients by delaying the start or continuation of necessary
treatment. The manual, time-consuming and varied processes used in prior
authorization programs burden physicians, divert valuable resources away from direct
patient care, and lead to negative patient outcomes.

The AOA believes that generic medications should not require prior authorization. The
AOA further affirms that step therapy protocols used in prior authorization programs
delay access to treatments and hinder adherence. Therefore, the AOA maintains that
step therapy should not be mandatory for patients already on a course of treatment.
Ongoing care should continue while prior authorization approvals or step therapy
overrides are obtained. Patients should not be required to repeat or retry step therapy
protocols failed under previous benefit plans. Additionally, the AOA asserts that health
plans should restrict utilization management programs to “outlier” physicians whose
prescribing or ordering patterns differ significantly from their peers after adjusting for
patient mix and other relevant factors; and, be it further

RESOLVED, that the AOA assert and advocate to legislators, insurance companies, and
insurance regulatory bodies that formulary changes should not occur more than 1 time
per year and that any change require a 90 day written notice to the patient and
prescribing physician that includes rationale for the change, and where the prescribed
device or medication can be obtained; and, be it further

RESOLVED, that the AOA formally join other stakeholders in publicly supporting & affirming
the “Prior Authorization and Utilization Management Reform Principles”
(https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-
with-signatory-page-for-slsc.pdf) in addition to the aforementioned policy statement;
and, be it further

RESOLVED, that the AOA consider adoption of the above policy statement in addition to the
AOA’s existing policy on prior authorization (H640-A/16 PRIOR
AUTHORIZATION, etc.).

References
1. “1 in 4 doctors say prior authorization has led to a serious adverse event” in AMA News,
https://www.ama-assn.org/practice-management/sustainability/1-4-doctors-say-prior-

Explanatory Statement:

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: ADDRESSING THE GENDER PAY GAP IN THE MEDICAL PROFESSION

SUBMITTED BY: The Student Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, the average female practicing physician can expect to earn as much as 37% less than her average male colleague; and

WHEREAS, a recent study reports that female physicians working with an academic appointment at public medical schools in the US can expect to earn, on average, 19.8% less than their male colleagues; and

WHEREAS, in a recent survey it was reported that female resident physicians can expect to earn, on average, as much as $900 less than their male colleagues and where other studies have shown that newly practicing female physicians can earn as much as 17% less than their male colleagues; and

WHEREAS, these disparities in income persist despite current United States federal law mandating the equal compensation of men and women for equal work in the same establishment and with due respect to permissible ‘affirmative defenses’ under the Equal Pay Act of 1963; and

WHEREAS, literature supports that these disparities in income persist even when factors that may contribute to them, including but not limited to, choice of specialty, family dynamics, working environment, and individual earning characteristics are controlled for; and

WHEREAS, these disparities in income are likely to appear early in a woman’s career, persist throughout it, and even widen as women continue to practice throughout their career; and

WHEREAS, these disparities in income between women and men, referred to as the “gender pay gap”, may result from a system of inequality at the detriment of women in the medical profession; and

WHEREAS, AOA Policy H207-A/17 NON-GENDER DISCRIMINATION, reads, “The American Osteopathic Association requires all of its recognized training institutions, both osteopathic and allopathic, to provide equally for their all physicians and students”; now, therefore be it,

RESOLVED, that the American Osteopathic Association (AOA) acknowledge the existence of the “gender pay gap” between male and female physicians in the United States; and, be it further
RESOLVED, that AOA shall support the adoption of policies and practices that ensure the equitable compensation of physicians regardless of gender who work with the same job title and job description, and with equivalent or comparable credentials and qualifications, requiring the same responsibility, effort, and skill, and under similar working circumstances in the academic, clinical, and support programs that are promoted by, accredited by, endorsed by, or otherwise funded by the AOA.

References

Explanatory Statement:
Please note that the use of the phrase “evidence-based” throughout this resolution is intended to specify that any policies or actions that arise from the adoption of this resolution ought to be based on available evidence and analysis rather than anecdote or conjecture. Further, note that the phrase “affirmative defenses” used in line 12 is a legal term used to describe those permissible discrepancies in compensation which are based on factors other than sex that include seniority, merit, quantity or quality of production by which employees may be compensated differently as established in the Equal Pay Act of 1963.

ACTION TAKEN ______________________

DATE ______________________________