HOUSE OF DELEGATES’
AD HOC REFERENCE COMMITTEE

(600 series) - This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.

<table>
<thead>
<tr>
<th>Res. No.</th>
<th>Resolution Title</th>
<th>Submitted By</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-600</td>
<td>Centers for Medicare and Medicaid Services Policies (H601-A/13)</td>
<td>BFHP</td>
<td>APPROVED</td>
</tr>
<tr>
<td>H-601</td>
<td>Centers for Medicare and Medicaid – Regulatory Reform (H602-A/13)</td>
<td>BSA</td>
<td>APPROVED</td>
</tr>
<tr>
<td>H-602</td>
<td>Centers for Medicare and Medicaid Services’ Method in Calculation Patient Services -- A Change in (H603-A/13)</td>
<td>BSA</td>
<td>APPROVED (for sunset)</td>
</tr>
<tr>
<td>H-603</td>
<td>Colorectal Cancer Screening -- Reimbursement for (H604-A/13)</td>
<td>BSA</td>
<td>APPROVED as AMENDED</td>
</tr>
<tr>
<td>H-604</td>
<td>Physician – Co-Management of a Patient (H605-A/13)</td>
<td>BSA</td>
<td>APPROVED as AMENDED</td>
</tr>
<tr>
<td>H-605</td>
<td>Criminal Litigation for Clinical Decisions (H606-A/13)</td>
<td>BSGA</td>
<td>APPROVED as AMENDED</td>
</tr>
<tr>
<td>H-606</td>
<td>Recovery Audit Contractors (RACs) – Payment of (H607-A/13)</td>
<td>BSA</td>
<td>APPROVED</td>
</tr>
<tr>
<td>H-607</td>
<td>Opposing Policies by Third Party Payors (Health Insurers) that May Negatively Impact the Provision of Healthcare (H609-A/13)</td>
<td>BSA</td>
<td>APPROVED as AMENDED</td>
</tr>
<tr>
<td>H-608</td>
<td>Current Procedural Terminology Codes 98925-98929, Qualifications for the Practice of Osteopathic Manipulative Treatment and the Coding and Billing for (H610-A/13)</td>
<td>BSA</td>
<td>APPROVED</td>
</tr>
<tr>
<td>H-609</td>
<td>Geriatrics --Lack of Liability Insurance Coverage for Practitioners of (H612-A/13)</td>
<td>BFHP</td>
<td>APPROVED (for sunset)</td>
</tr>
<tr>
<td>H-610</td>
<td>ICD-9 Codes for Laboratory Tests -- Assignment of Appropriate (H613-A/13)</td>
<td>BSA</td>
<td>APPROVED as AMENDED</td>
</tr>
<tr>
<td>H-611</td>
<td>Osteopathic Graduate Medical Education (H614-A/13)</td>
<td>COGMED</td>
<td>APPROVED as AMENDED</td>
</tr>
<tr>
<td>H-612</td>
<td>Postpartum Depression (H615-A/13)</td>
<td>BSAPH</td>
<td>REFERRED</td>
</tr>
<tr>
<td>Res. No.</td>
<td>Resolution Title</td>
<td>Submitted By</td>
<td>Action</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>H-613</td>
<td>Tobacco Use in Entertainment Media (H616-A/13)</td>
<td>BSAPH</td>
<td>APPROVED as AMENDED</td>
</tr>
<tr>
<td>H-614</td>
<td>Veterans – Health Care for US (H617-A/13)</td>
<td>BFHP</td>
<td>APPROVED as AMENDED</td>
</tr>
<tr>
<td>H-615</td>
<td>Taser Safety (H618-A/13)</td>
<td>BSAPH</td>
<td>APPROVED</td>
</tr>
<tr>
<td>H-616</td>
<td>Centers for Medicare and Medicaid Services’ – Burdensome Requirements for Diabetic Supplies (H619-A/13)</td>
<td>BSA</td>
<td>APPROVED as AMENDED</td>
</tr>
<tr>
<td>H-617</td>
<td>Tenets of Osteopathic Medicine (H622-A/13)</td>
<td>BOE</td>
<td>APPROVED</td>
</tr>
<tr>
<td>H-618</td>
<td>AOA Accreditation of Sponsors Providing Osteopathic Continuing Medical Education (AOA Category 1-A)</td>
<td>POMA /et al</td>
<td>APPROVED</td>
</tr>
<tr>
<td>H-619</td>
<td>Demographics to be Shared with Affiliates</td>
<td>IOMA</td>
<td>DISAPPROVED</td>
</tr>
<tr>
<td>H-620</td>
<td>Electronic Availability of AOA House of Delegates</td>
<td>NYSOMS</td>
<td>DISAPPROVED</td>
</tr>
<tr>
<td>H-621</td>
<td>Group Purchasing Organizations – Effect on Healthcare Costs</td>
<td>MAOPS</td>
<td>DISAPPROVED</td>
</tr>
<tr>
<td>H-622</td>
<td>Inclusion of Osteopathic Language and Structural Exam in Electronic Health Record Systems</td>
<td>IOMA</td>
<td>APPROVED as AMENDED</td>
</tr>
<tr>
<td>H-623</td>
<td>H613-A/15 Non-Physician Clinicians</td>
<td>BSGA</td>
<td>APPROVED as AMENDED</td>
</tr>
<tr>
<td>H-624</td>
<td>WITHDRAWN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H-625</td>
<td>Access to Health Care/Health Insurance</td>
<td>SOMA</td>
<td>REFERRED</td>
</tr>
<tr>
<td>H-626</td>
<td>Adoption of Expedited Partner Therapy (EPT) Policy and Advocacy for National Legalization of Interstate Opioid Database</td>
<td>SOMA</td>
<td>APPROVED as AMENDED</td>
</tr>
<tr>
<td>H-627</td>
<td>Advocating for the Repeal of the Dickey Amendment, and Public Health Research on Firearm Violence</td>
<td>SOMA</td>
<td>DISAPPROVED</td>
</tr>
<tr>
<td>H-628</td>
<td>Cannabis Reclassification: Effect on Research</td>
<td>SOMA</td>
<td>APPROVED</td>
</tr>
<tr>
<td>H-629</td>
<td>Combating Pharmaceutical Evergreening to Decrease Healthcare Costs and Increase Quality, Competition</td>
<td>SOMA</td>
<td>APPROVED</td>
</tr>
<tr>
<td>Res. No.</td>
<td>Resolution Title</td>
<td>Submitted By</td>
<td>Action</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>H-630</td>
<td>Comprehensive Gun Violence Reform</td>
<td>SOMA</td>
<td>APPROVED as AMENDED</td>
</tr>
<tr>
<td>H-631</td>
<td>Increased Resources and Accessibility for LGBTQ Persons in Federally Funded Halfway Houses</td>
<td>SOMA</td>
<td>DISAPPROVED</td>
</tr>
<tr>
<td>H-632</td>
<td>Increasing the Education and Preventative Prescribing of Naloxone use for Opioid Overdose</td>
<td>SOMA</td>
<td>APPROVED as AMENDED</td>
</tr>
<tr>
<td>H-633</td>
<td>Opposing Immigration and Customs Enforcement at Sensitive Locations</td>
<td>SOMA</td>
<td>DISAPPROVED</td>
</tr>
<tr>
<td>H-634</td>
<td>Recognizing Sexual Assault Survivors’ Rights</td>
<td>SOMA</td>
<td>APPROVED as AMENDED</td>
</tr>
<tr>
<td>H-635</td>
<td>Religious Freedom and Ethical Medical Practice</td>
<td>SOMA</td>
<td>DISAPPROVED</td>
</tr>
<tr>
<td>H-636</td>
<td>Standing Against Restrictive Housing and Solitary Confinement for Juvenile Inmates of Prison Systems in the US</td>
<td>SOMA</td>
<td>REFERRED</td>
</tr>
<tr>
<td>H-637</td>
<td>Urge Congress to Retain DACA Protections</td>
<td>SOMA</td>
<td>APPROVED as AMENDED</td>
</tr>
</tbody>
</table>
RESOLVED, that the Bureau of Federal Health Programs recommend that the following policy be REAFFIRMED:

H601-A/13 CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) POLICIES

The American Osteopathic Association 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. 1998; revised 2003; reaffirmed 2008; 2013.

ACTION TAKEN _APPROVED (for reaffirmation)_

DATE _July 21, 2018_
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED:

H602-A/13 CENTERS FOR MEDICARE AND MEDICAID (CMS) – REGULATORY REFORM

The American Osteopathic Association will: (1) remain committed to securing the enactment of comprehensive reforms that reduce the regulatory burden and allow physicians to dedicate the majority of their time to providing patient care; (2) urge the Centers for Medicaid and Medicare Services (CMS) to provide more physician education regarding Medicare policies, procedures, and regulations, particularly in rural and frontier areas; and (3) support actions that will hold carriers accountable for providing inaccurate information to physicians. 2003; reaffirmed 2008; reaffirmed as amended 2013.

ACTION TAKEN APPROVED (for reaffirmation)

DATE July 21, 2018
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be SUNSET:

H603-A/13 CENTERS FOR MEDICARE AND MEDICAID SERVICES’ (CMS) METHOD IN CALCULATION PATIENT SERVICES -- A CHANGE IN

The American Osteopathic Association endorses the Centers for Medicare and Medicaid Services proposal that divides Physician Services into separate categories of Direct Physician Services and Referral Physician Services to provide the true expenditure of health services.


Explanatory Statement:
This CMS initiative is no longer active, and the policy is no longer relevant.

ACTION TAKEN: APPROVED (for sunset)

DATE: July 21, 2018
SUBJECT: H604-A/13 COLORECTAL CANCER SCREENING -- REIMBURSEMENT FOR

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:

H604-A/13 COLORECTAL CANCER SCREENING -- REIMBURSEMENT FOR PAYMENT FOR


ACTION TAKEN APPROVED as AMENDED

DATE July 21, 2018
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H605-A/13 PHYSICIAN – CO-MANAGEMENT OF A PATIENT

The American Osteopathic Association’s policy on co-management of a patient, requires 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 he/she arrange for an osteopathic or allopathic physician to provide for the pre-procedural and post-procedural care. In cases where only A physician extenders are available IS UNAVAILABLE, appropriate physician supervision should continue as defined by state law THE PHYSICIAN EXTENDERS NON-PHYSICIAN CLINICIANS SHOULD BE UNDER DIRECT PHYSICIAN SUPERVISION, IN ACCORDANCE WITH THE STATE LAW. 2002, revised 2003; reaffirmed 2008; reaffirmed as amended 2013.

ACTION TAKEN _APPROVED as AMENDED

DATE _July 21, 2018_
RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H606-A/13  CRIMINAL LIABILITY LITIGATION FOR CLINICAL DECISIONS

The American Osteopathic Association opposes criminal prosecution of LIABILITY FOR a physician whose clinical decisions were made without malice and in good faith. 1998, revised 2003; reaffirmed 2008; reaffirmed as amended 2013.

ACTION TAKEN  APPROVED (as amended)

DATE  July 21, 2018
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED:

H607-A/13  RECOVERY AUDIT CONTRACTORS (RACs) – PAYMENT OF

The American Osteopathic Association supports removing the contingency payment of Recovery Audit Contractors (RACs) replacing with a flat-rate compensation. 2013.

ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 21, 2018
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

**H609-A/13  OPPOSING POLICIES BY THIRD PARTY PAYORS (HEALTH INSURERS) THAT MAY NEGATIVELY IMPACT THE PROVISION OF HEALTHCARE**

The American Osteopathic Association TO PRESERVE THE PHYSICIAN-PATIENT RELATIONSHIP AND PHYSICIAN CLINICAL JUDGEMENT AS THE BASIS FOR FORMULATING AN INDIVIDUAL PLAN OF CARE, (1) believes that SUPPORTS POLICY REQUIRING THAT third party payors (health insurers) should assist physicians by publishing their guidelines and rationales for exceptions to expedite care; (2) opposes policies and any practice of third party payors (health insurers) that replace physician clinical judgment with a fixed protocol or potentially less effective medications for required trial of treatment; AND (3) opposes policies and any practice of third party payors (health insurers) that replace physician clinical judgment with a fixed protocol of prerequisite of diagnostic procedures; and (4) will work with national physician organizations, state and osteopathic specialty societies to preserve the physician patient relationship and physician clinical judgment as the basis for formulating an individual plan of care. 2013.

Reference Committee Explanatory Statement:
The Committee believes that the parenthetic references to health insurers in H-607 are limiting and fail to reflect the more broad intent of the resolution. Third party payors are not necessarily health insurers and, given the evolving payor landscape, could include a number of organizations or actors that pay for medical expenses on behalf of beneficiaries, members or recipients.

**ACTION TAKEN** APPROVED as AMENDED

**DATE** July 21, 2018
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H610-A/13 CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES 98925-98929, QUALIFICATIONS FOR THE PRACTICE OF OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) AND THE CODING AND BILLING FOR

The American Osteopathic Association believes that only fully licensed physicians are qualified to perform and report osteopathic manipulative treatment (OMT) with CPT Codes 98925-98929, and will communicate its concerns regarding the inappropriateness of the language changes in the 2013 CPT codes for OMT to the CPT Editorial Panel, 2013.

ACTION TAKEN _APPROVED (as amended)_

DATE _July 21, 2018_
SUBJECT: H612-A/13 GERIATRICS --LACK OF LIABILITY INSURANCE COVERAGE FOR PRACTITIONERS OF

SUBMITTED BY: Bureau of Federal Health Programs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Federal Health Programs recommend that the following policy be REAFFECTTED SUNSET:

H612-A/13 GERIATRICS --LACK OF LIABILITY INSURANCE COVERAGE FOR PRACTITIONERS OF

The American Osteopathic Association: (1) publicly oppose any medical liability insurance industry policy which excludes offering coverage to physicians providing geriatric care and work to have such a policy rescinded; (2) will coordinate its efforts with other organizations similarly opposed to this medical liability insurance industry policy in order to enhance success; (3) will advocate its opposition to those legislative and governmental entities who have impact on allowing the medical liability insurance industry to restrain trade; and (4) will investigate this issue for its national implications and to intervene as appropriate. 2003; 2008; reaffirmed as amended 2013.

Reference Committee Explanatory Statement:
The policy is out of date because most geriatricians now have access to liability insurance, and the American Osteopathic Association will be able to assist the few that do not.

ACTION TAKEN APPROVED (for sunset)

DATE July 21, 2018
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

**H613-A/13 ICD-9 CODES FOR LABORATORY TESTS -- ASSIGNMENT OF APPROPRIATE**

It is the policy of the American Osteopathic Association that 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 US Congress. 1998, revised 2003; 2008; reaffirmed as amended 2013.

**ACTION TAKEN**: **APPROVED as AMENDED**

**DATE**: **July 21, 2018**
RESOLVED, that the Council on Osteopathic GME Development recommend that the following policy be REAFFIRMED as AMENDED:

H614-A/13 OSTEOPATHIC GRADUATE MEDICAL EDUCATION

The American Osteopathic Association urges its member physicians to support hospitals that provide osteopathic postdoctoral training programs, **INCLUDING PARTICULARLY** THOSE WITH OSTEOPATHIC RECOGNITION THROUGH ACGME, which are an integral part of osteopathic medical education. 1998 revised 2003; 2008; reaffirmed 2013.

ACTION TAKEN **APPROVED** as **AMENDED**

DATE **July 21, 2018**
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

**H615-A/13 POSTPARTUM DEPRESSION**

The American Osteopathic Association encourages its members to participate in continuing medical education programs on postpartum depression (PPD); urges colleges of osteopathic medicine (COMs) and osteopathic state and specialty associations to offer CME on PPD as part of their educational offerings; and endorses the use of screening tools and encourage the measurement of outcomes in their use. 2003; 2008; reaffirmed as amended 2013.

Reference Committee Explanatory Statement:
The Committee requests that the Bureau of Scientific Affairs and Public Health (BSAPH) produce a report on outcomes to be delivered to the House of Delegates in July 2019.

**ACTION TAKEN** REFERRED (to BSAPH)

**DATE** July 21, 2018
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H616-A/13  TOBACCO USE IN ENTERTAINMENT MEDIA

ACTION TAKEN  APPROVED as AMENDED

DATE  July 21, 2018
RESOLVED, that the Bureau of Federal Health Programs recommend that the following policy be REAFFIRMED:

**H617-A/13 VETERANS – HEALTH CARE FOR US**

The American Osteopathic Association supports adequate health care funding by the federal government to provide HEALTH care for all US Veterans at Veterans Health Administration facilities and supports federal funding for veterans to utilize community physicians for care when Veterans’ Health Administration facilities cannot provide adequate or timely access. 2003; 2008; reaffirmed 2013.

ACTION TAKEN  **APPROVED as AMENDED**

DATE  **July 21, 2018**
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
following policy be REAFFIRMED:

H618-A/13  TASER SAFETY
The American Osteopathic Association encourages further research on cardiac arrest, death,
and other adverse health effects associated with shocks from taser electronic control devices.
2008; reaffirmed as amended 2013.

ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 21, 2018
SUBJECT: H619-A/13 CENTERS FOR MEDICARE AND MEDICAID SERVICES’ (CMS) – BURDENSOME REQUIREMENTS FOR DIABETIC SUPPLIES

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:

H619-A/13 CENTERS FOR MEDICARE AND MEDICAID SERVICES’ (CMS) – BURDENSOME REQUIREMENTS FOR DIABETIC SUPPLIES

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

The American Osteopathic Association SHALL MAKE THE REDUCTION OF ADMINISTRATIVE BURDENS A TOP PRIORITY AND IMMEDIATELY DEVOTE THE NECESSARY RESOURCES TO WILL WORK WITH recommends that CMS to develop a less burdensome REQUIREMENTS THAT ASSIST PHYSICIAN EFFICIENCY, PROTECT PATIENT CONFIDENTIALITY, AND DO NOT RESULT IN A DUPLICATION OF EFFORTS FOR PHYSICIANS WHEN PROVIDING DOCUMENTATION OF MEDICAL NECESSITY FOR ALL DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES AND OTHER COVERED MEDICARE AND MEDICAID SERVICES. procedure PROCESSES for physicians to provide documentation of medical necessity for ALL DURABLE MEDICAL EQUIPMENT diabetic supplies and other covered CMS services that INCREASE PHYSICIAN EFFICIENCY, protect patient confidentiality and do not result in duplication of documentation. 2013.

ACTION TAKEN APPROVED as AMENDED

DATE July 21, 2018
RESOLVED, that the Bureau of Education recommend that the following policy be REAFFIRMED:

H622-A/13  TENETS OF OSTEOPATHIC MEDICINE

The American Osteopathic Association approves as policy 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. 2008; reaffirmed 2013.

ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 21, 2018
RES. NO. H-618 - A/2018 – Page 1

SUBJECT: AOA ACCREDITATION OF SPONSORS PROVIDING OSTEOPATHIC CONTINUING MEDICAL EDUCATION (AOA CATEGORY 1-A)


REFERRED TO: Ad Hoc Committee

WHEREAS, AOA Category 1A Continuing Medical Education (CME) credit, as described and approved by the American Osteopathic Association (AOA) is required for and to maintain medical licensure in 11 states; and

WHEREAS, the eighteen Osteopathic Specialty Boards represented within the Bureau of Osteopathic Specialists (BOS) are continuing to identify specialty requirements for CME as described in RES. No. BOT-9-M/2017; and

WHEREAS, Osteopathic CME is considered an integral component of the continuum of osteopathic medical education and a requisite area of accreditation by the Commission on Osteopathic College Accreditation (Standard 10, Element 10.1: Osteopathic Educational Continuum: The COM must demonstrate policy, structure and procedures to support the continuum of osteopathic education - including predoctoral education, graduate medical education, and continuing medical education. The COM must provide a copy of its policies and procedures demonstrating its support of the continuum of osteopathic education.); and

WHEREAS, certain affiliate members of the AOA and Colleges of Osteopathic Medicine accredited by the Commission on Osteopathic College Accreditation have been previously mandated to maintain AOA CME Sponsorships; and

WHEREAS, affiliate organizations, especially State Societies and Specialty Colleges, include education of osteopathic physicians as a major reason for receiving status as a tax-exempt organization ((501(c)3 or (6)) under the federal tax code of the United States; now, therefore be it

RESOLVED, that 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.
Explanatory Statement:
The states with specific requirements for AOA approved Category 1A CME include Arizona, California, Florida, Maine, Michigan, Nevada, Oklahoma, Pennsylvania, Tennessee, Texas, and West Virginia.

RES. No. B-9-M/2017 is attached as Addenda A.

The federal tax code requirements for tax exemption:
501(c)(3) - The exempt purposes set forth in section 501(c)(3) are charitable, religious, educational, scientific, literary, testing for public safety, fostering national or international amateur sports competition, and preventing cruelty to children or animals. The term charitable is used in its generally accepted legal sense and includes relief of the poor, the distressed, or the underprivileged; advancement of religion; advancement of education or science; erecting or maintaining public buildings, monuments, or works; lessening the burdens of government; lessening neighborhood tensions; eliminating prejudice and discrimination; defending human and civil rights secured by law; and combating community deterioration and juvenile delinquency.

501(c)(6) Definition is attached as Addenda B

Fiscal Impact:
The American Osteopathic Association will have no additional cost associated with this resolution as they currently maintain employees who accredit, review, and assist with the CME process. The AOA also currently maintains and supports the Council on Osteopathic Continuing Medical Education, which could remain as the approval body for CME sponsorship without additional cost. Elimination of osteopathic CME could be associated with revenue loss from lack of sponsor payments, loss of affiliate members, and reduction of CME activities at national and regional conferences such as OMED, OMEL/LEAD, and ROME.

Reference Committee Explanatory Statement
THE COMMITTEE SUPPORTS THIS RESOLUTION TO STRENGTHEN THE COLLEGIALITY BETWEEN THE AOA AND ITS AFFILIATES AND TO ENSURE THAT THE AFFILIATES CONTINUE TO HAVE THE ABILITY TO PROVIDE QUALITY CME PROGRAMS TO THE OSTEOPATHIC PHYSICIANS THEY SERVE.

ACTION TAKEN \[\text{APPROVED}\]

DATE \[\text{July 21, 2019}\]
WHEREAS, the American Osteopathic Association (AOA) collects and stores the
demographic and other data of students, residents, fellows and practicing physicians;
and

WHEREAS, the affiliate organizations many times have difficulty obtaining this information
from reliable sources for a variety of reasons including prohibitive cost; and

WHEREAS, recent AOA Board resolutions acknowledge this fact and recommend sharing data
and demographics where permissible by law and agreements; now, therefore be it

RESOLVED, that the American Osteopathic Association provide this information at little or
no charge to the affiliate organizations when requested.

Reference Committee Explanatory Statement:
The Committee believes this resolution is more comprehensively represented by resolution B-9
approved at the 2018 Midyear Meeting.

ACTION TAKEN  DISAPPROVED

DATE  July 21, 2018
WHEREAS, the American Osteopathic Association (AOA) House of Delegates (House) addresses hundreds of resolutions as part of its yearly business; and

WHEREAS, all resolutions are reviewed by reference committees; and

WHEREAS, it is the charge of each reference committee to hear testimony from members of the osteopathic community who often make recommendations as to changes, improvements, deletions of sections and editorial changes; and

WHEREAS, as a cost-saving and environmental protection measure, the AOA does not make paper hard copy versions available for the large majority of the proposed resolutions; and

WHEREAS, the files for the resolutions are available on the AOA web-site digitally in a pdf format; and

WHEREAS, free limited pdf programs are available for download; and

WHEREAS, these pdf programs allow for limited license use and these limitations allow for opening and reading files but do not typically allow for editing and saving changes; and

WHEREAS, opening and editing in a Microsoft Word ® format is much easier and is used during the House sessions when the chairs of reference committees present resolutions for voting; and

WHEREAS, having Microsoft Word ® document versions would make it easier for those who have a version of this program to annotate, add comment, edit and track changes; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) will make both word document and pdf formats of proposed resolutions available for downloading by HOD delegates.

Reference Committee Explanatory Statement:
The Committee believes offering resolutions in any format that would allow for editing could damage the integrity of the original submission.

ACTION TAKEN DISAPPROVED

DATE July 21, 2018
WHEREAS, the Medicare Medicaid Patient and Protection Act of 1987 created safe harbors in
the anti-kickback statutes for the creation of Group Purchasing Organizations (GPOs)
allowing program providers to join together with the intention to gain cost savings; and

WHEREAS, this provision allowed the GPOs to receive funds from suppliers to gain access,
some of which is passed along to members of the GPOs to entice membership; and

WHEREAS, this has led to a pay-to-play scheme resulting in nationwide shortages of basic
supplies and pharmaceuticals while benefiting the GPOs, but resulting in an estimated
$200 billion in excess costs to the healthcare system; now, therefore be it

RESOLVED, that the American Osteopathic Association’s Bureau of Federal Health Programs
develop a position paper on safe harbor protections for Group Purchasing
Organizations outlining the benefits and disadvantages of such protections and the
overall impact on the supply and costs of basic medical supplies and pharmaceuticals.

Reference Committee Explanatory Statement:
The Committee believes subsequent to discussion, the Committee was made aware that a GPO is
currently offered by the American Osteopathic Information Association (AOIA). Thus, the Committee
is confident that information on safe harbor guidelines can be provided through coordination with the
AOIA without requiring the formal development of a position paper.

ACTION TAKEN  DISAPPROVED

DATE  July 21, 2018
RES. NO. H-622 - A/2018 – Page 1

SUBJECT: INCLUSION OF OSTEOPATHIC LANGUAGE AND STRUCTURAL EXAM IN ELECTRONIC HEALTH RECORD SYSTEMS

SUBMITTED BY: Iowa Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

1 WHEREAS, the vast majority of osteopathic physicians have adopted the use of electronic health records (EHR); and

2 WHEREAS, in the future, EHR use will be universal; and

3 WHEREAS, there are now more than 100,000 osteopathic physicians practicing in the United States; and

4 WHEREAS, osteopathic medical students now comprise approximately 25% of all medical students in the U.S.; and

5 WHEREAS, very few EHR systems currently include osteopathic structural exams and osteopathic terminology including the most popular EHR systems currently in use; and

6 WHEREAS, this makes it difficult to document and bill for Osteopathic manipulative services and Osteopathic comprehensive care; now, therefore be it

RESOLVED, that THE American Osteopathic Association (AOA) WILL CONTINUE TO actively advocate for the inclusion of Osteopathic PATHICALLY-FOCUSED structural exams and Osteopathic terminology AND STRUCTURAL EXAM TEMPLATES WITHIN all current and future major electronic health records systems; and, be it further

RESOLVED, that the AOA report back to the House of Delegates at the 2019 annual meeting on the activity taken to implement this resolution and on the results of that activity.

ACTION TAKEN _APPROVED as AMENDED_

DATE _July 21, 2018_
RESOLVED, that the Bureau of State Government Affairs recommends that American
Osteopathic Association policy H613-A/15 NON-PHYSICIAN CLINICIANS be
updated with the following language:

H613-A/15 NON-PHYSICIAN CLINICIANS
The American Osteopathic Association has adopted the attached policy paper as its position on

Policy Statement - 2018
NON-PHYSICIAN CLINICIANS
The practice of medicine and the quality of medical care are the responsibility of properly
licensed physicians. The DO/MD medical model has proven its ability to provide
professionals with complete medical education, and training AND TESTING NEEDED TO
ENSURE PATIENT SAFETY. THUS, IT IS APPROPRIATE THAT THE PRACTICE OF
MEDICINE AND THE QUALITY OF MEDICAL CARE ARE THE RESPONSIBILITY
OF PROPERLY LICENSED PHYSICIANS. THE AOA FURTHER SUPPORTS THE
CONCEPT OF UNIFORM LICENSURE PATHWAYS FOR PHYSICIANS, AS WELL
AS NON-PHYSICIAN CLINICIANS, BASED UPON SCOPE OF PRACTICE. IT
OPPOSES ANY LEGISLATION OR REGULATIONS WHICH WOULD AUTHORIZE
THE INDEPENDENT PRACTICE OF MEDICINE BY ANY INDIVIDUAL WHO HAS
NOT COMPLETED THE STATE'S REQUIREMENTS FOR PHYSICIAN LICENSURE;
their leadership in such an approach is logical and most appropriate.

AS NON-PHYSICIAN CLINICIANS CONTINUE TO SEEK WIDER ROLES, Public
policy dictates 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. However, it is the AOA’s position that new roles for non-physician
clinicians may be granted after appropriate processes and programs are established in all of the
following four areas: education, training, examination, and regulation. It is further the AOA’s
stance that non-physician clinicians may be allowed to expand their rights only after it is proven
they have the ability to provide healthcare within these new roles safely and effectively.

B. Independent Practice. It is the AOA’s position that roles within the “team” framework
must be clearly defined, through established protocols and signed agreements, so physician
involvement in patient care is sought when a patient's case dictates. The AOA feels non-
physician 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. 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 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 autonomously of physicians should be held to the equivalent degree of liability
as that of a physician. Within this independent practice framework, the AOA further believes
that non-physician clinicians should be required to obtain malpractice insurance in those states
that currently require physicians to possess malpractice insurance.

D. Educational Standards. DOs/MDs have proven and continue to prove the efficacy of
their education, training, examinations, and regulation AND PHYSICIAN INVOLVEMENT
for the unlimited practice of medicine and it is the AOA's firm conviction that only holders of
DO and MD degrees be licensed for medicine's unlimited practice. The osteopathic profession
has continually proven its ability to meet and exceed standards necessary for the unlimited
practice of medicine, as non-physician clinicians seek wider roles, standards of education,
training, examination, and regulation AND PHYSICIAN INVOLVEMENT' must all be
adopted to protect the patient and ensure that proper patient care is being given. The AOA
holds the position that education, training, examination and regulation must all be documented
and reflective of the expanded scopes of practice being sought by non-physician clinicians. The
AOA recognizes there may be a need for an objective, independent body to review and validate
non-physician clinician standards.

Explanatory Statement:
Although this policy was last reviewed less than five years ago, amendments are needed in order to
strengthen our response to the large and varied scope of practice expansion attempts we continue to
see by non-physician clinicians, in order to clarify our position that the practice of medicine must be
reserved for physicians (DOs and MDs).

ACTION TAKEN _APPROVED as AMENDED

DATE _July 21, 2018_
SUBJECT: ACCESS TO HEALTH CARE/HEALTH INSURANCE

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, the percentage of uninsured people in America was 8.8% in 2016 which is equivalent to 28.1 million people; and

WHEREAS, the U.S. consistently ranks lower than nearly every other developed nation on measures of health system quality, efficiency, access to care, equity, and healthy living; and

WHEREAS, the high cost of healthcare contributed to 62.1% of all bankruptcies in the U.S.; and

WHEREAS, this high cost is devastating even for those with insurance as the average out of pocket costs for medically bankrupt families was $17,943 and 69.2% of the debtors or dependents in medical bankruptcy were insured when they filed for bankruptcy; and

WHEREAS, billing and insurance-related activities in the U.S. health care system totaled $471 billion in 2012 and a Medicare for All financing system is projected to result in administrative cost savings exceeding $350 billion annually; and

WHEREAS, a Medicare for All system is estimated to save at least $200 billion annually in total healthcare spending “by eliminating the high overhead and profits of the private, investor owned insurance industry and reducing spending for marketing and other satellite services”; and

WHEREAS, AOA H314-A/13 says “The American Osteopathic Association has a priority goal to encourage the US Congress for passage of legislation to further the national health care debate; that this public debate address the major issues that threaten the ability of osteopathic physicians to provide quality cost-efficient health care to their communities, including the availability of affordable health insurance for all citizens…and that follow up activity assures that Congress enacts the appropriate legislation that assures the accomplishments of the above listed goals”; and

WHEREAS, in a 2016 Gallup poll, 58% of American citizens approve replacing the ACA with a federally funded health care system that provides insurance for all Americans; and

WHEREAS, in another 2016 Gallup poll, 77% of people on Medicare said they were happy with their health insurance, compared with 69% of people on employer funded insurance and 65% of people on private self-paid insurance; and

WHEREAS, the following organizations have already come out in support of a Medicare for All bill, House Resolution 676: American Association of Community Psychiatrists,
RESOLVED, that the American Osteopathic Association (AOA) advocates for and supports an expanded and improved "Medicare for All" single payer health care system in the United states defined as a single public insurer providing health insurance to include coverage for all medically necessary services including doctor, hospital, preventive care, long term care, mental health care, reproductive health care, dental care, vision care, and prescription drug and medical supply costs for all residents of the United States with no out-of-pocket costs or copay.

References
Explanatory Statement:
Medicare for all is a system in which a single public or quasi-public agency organizes health care financing, but the delivery of care remains largely in private hands. Such a system would provide insurance covering all medically necessary care as listed below at no out of pocket cost to all residents of the United States and does not call for or create a socialized delivery of care system. There are currently two Medicare for All bills in Congress, one in the House of Representatives and one in the Senate, HR 676 and S-000. HR 676 is co-sponsored by 117 representatives and S-000 is co-sponsored by 16 senators. This is an opportunity for the AOA to be a leader in healthcare. Per PEW, two thirds of Americans aged 20-30 believe that the government should bear the responsibility of providing healthcare to its citizens, with one third saying they want a single payer health care system. These numbers continue to rise and we feel we must take control of this narrative and discussion or we face risk of other actors within healthcare to craft health care reform at our expense and without the patient’s best interest in mind. The means to achieving increased access to care for all is outlined in the resolution below.

Medicare for All as outlined in the resolution would accomplish several AOA Federal Policy Priorities. Not only would it demand continued and sufficient funding, without erosion of benefits, eligibility, or coverage, it would expand them. It would also prevent not just loss of coverage due to action of policy makers, but would more fully prevent loss of coverage by inaction of policy makers than perhaps any other measure suggested. And a single payer system would reduce paperwork and cut down on hours lost to billing as physicians and/or their practices would not have to consult several different companies and their unique, often complex standards for pre-authorization and/or coverage. It would therefore be a means to accomplish entitlement reform by expanding access to care while enacting regulatory reform that would free up time and resources to provide better patient care.

Reference Committee Explanatory Statement:
The Committee believes that existing AOA policy H341-A/13 “Uninsured-Access to Health Care” supports the intent of the proposed resolution.

ACTION TAKEN REFERRED (to BSAPH)

DATE July 21, 2018
Subjekt: Adoption of Advocate for Expedited Partner Therapy (EPT) Policy and Advocacy for National Legalization of Interstate Opioid Database

Submitted by: Student Osteopathic Medical Association

Referred to: Ad Hoc Committee

WHEREAS, in the 2006 Centers for Disease Control (CDC) Expedited Partner Therapy in the Management of Sexually Transmitted Diseases Review and Guidance White Paper endorses the use of Expedited Partner Therapy (EPT), defined as “the practice of treating the sex partners of persons with sexually transmitted diseases (STD) without an intervening medical evaluation or professional prevention counseling. The usual implementation of EPT is through patient delivered partner therapy (PDPT), although other methods may be employed.”1; and

WHEREAS, the World Health Organization’s Global Health Sector Strategy on Sexually Transmitted Infections 2016-2021 Towards Ending STIs states “partner notification is integral to effective sexually transmitted infection prevention and care.” and “approaches for informing sex partners and offering them counseling and treatment vary according to circumstances and include patient referral (whereby patients are encouraged to contact their sex partners themselves), provider referral (the health care provider notifies the partner and arranges treatment), contractual patient–provider referral (a two-step approach that links patient and provider referral methods), and expedited partner therapy (the diagnosed patient takes the prescriptions or medication to his/her partner without prior examination of the partner)… The selected strategy has to be rights based and sensitive to gender inequalities, while ensuring and expediting partners’ access to treatment.”2; and

WHEREAS, the incidence of STIs is increasing based on a recent CDC report, with the rate of new Chlamydia infections increasing 4.7% since 2015 (1.59 million cases in 2016, 497.3/100,000), and the rate of new Gonorrhea infections increasing 18.5% since 2015 (468,514 cases in 2016, 145.8/100,000); and

WHEREAS, EPT is illegal in the states of Kentucky and South Carolina, and potentially allowable, but limited in Alabama, Delaware, Kansas, Oklahoma, New Jersey, South Dakota, Virginia and Puerto Rico; and

WHEREAS, current methods of patient referral for treatment of gonorrhea and chlamydial infections only reach 40-60% of named sexual partners; and

WHEREAS, based on the most recent CDC statistics, state legislative restrictions on EPT in the above states are currently potentially denying an evidence-based treatment option to approximately 190,856 patients diagnosed with chlamydia and 56,558 patients diagnosed with gonorrhea, totaling 247,414 patients; and
WHEREAS, in the 2006 CDC White Paper on EPT, based on evidence from four CDC-funded randomized controlled trials, the executive summary concludes that “The evidence indicates that EPT should be available to clinicians as an option for partner management”\(^1\), and that “preliminary economic analyses suggest that EPT is a cost-saving and cost effective partner management; and

WHEREAS, the American College of Obstetricians and Gynecologists\(^7\), the American Medical Association\(^8\), the American Academy of Family Physicians\(^9\), the Society for Adolescent Medicine\(^10\), and the American Academy of Pediatrics\(^11\), all have position statements in support of EPT and in support of legalization; and

WHEREAS, a policy adopted by the American Bar Association “urges states, territories and tribes to support the removal of legal barriers to the appropriate use by health care providers of EPT, applied as specified in protocols promulgated by the U.S. Centers for Disease Control and Prevention, in the treatment of those sexually transmitted diseases identified in the evidence-based recommendations of the CDC and the policy statements of the American Medical Association”\(^12\); and

WHEREAS, the American Osteopathic Association currently does not have any policy regarding EPT; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) endorse ADVOCATE FOR the use of Expedited Partner Therapy (EPT) in accordance with the evidence-BASED MEDICINE and IN ACCORDANCE WITH STATE LAWS, guidelines as outlined by the Centers for Disease Control (CDC); and, be it further

RESOLVED, that the AOA support legalization of EPT in all states in accordance with the evidence and guidelines as outlined by the CDC.

References


ACTION TAKEN **APPROVED** as AMENDED

DATE **July 21, 2018**
WHEREAS, firearm violence is defined as shooting of a victim by a subject/suspect; and

WHEREAS, firearm violence is a leading cause of premature death in the U.S, causing nearly 30,000 deaths and 60,000 injuries each year; and

WHEREAS, the United States has more gun murders per 100,000 people than any developed country in the world; and

WHEREAS, the Centers for Disease Control (CDC) considers opioid overdose and motor vehicle accidents to be public health issues; and

WHEREAS, in 2016, opioids were responsible for more than 42,000 fatalities and motor vehicle accidents were responsible for 37,461 fatalities with the former being declared a public health crisis emergency by the White House administration in October of 2016; and

WHEREAS, firearm violence is a public health concern and crisis per the most reputable organizations and institutions across the country including but not limited to the CDC, the American Medical Association and the American Public Health Association; and

WHEREAS, per analysis of CDC statistics in 2004-2014, “gun violence research was the least researched cause of death and the second least funded cause of death” in relation to mortality rates; and

WHEREAS, the “Dickey Amendment”, passed as part of the 1996 Omnibus Consolidated Appropriations Bill, currently restricts the CDC from researching firearm violence and its effects on public health; and

WHEREAS, the intent behind the “Dickey Amendment” was not to inhibit research on firearm control and Congressman Jay Dickey acknowledges the unintended consequences of the Dickey amendment; and

WHEREAS, in H450-A/15, the American Osteopathic Association (AOA) demonstrated support for increasing funding for the 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, however they did so without addressing the research ban put forth by the Dickey Amendment; and
WHEREAS, in 2015 the CDC issued a report in which they found the majority of individuals involved in urban firearm violence were young men with substantial violence involvement preceding the more serious offense of a firearm crime, and in the same report their findings suggested that integrating data systems to develop an accurate risk assessment tool that would facilitate violence prevention could help these individuals better receive early comprehensive help that they need to prevent violence; and

WHEREAS, the report does not address how perpetrators acquire weapons, or if attempts to limit access to firearms might lead to a decline in crime, or any definitive evidence based solution due to the lack of available research; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) take an official policy stance that firearm violence is a public health crisis; and, be it further

RESOLVED, that the AOA stand by its policy (HR 450-A/15 FIREARM VIOLENCE) and, therefore support and lobby for the removal of the Dickey Amendment and/or any other restriction on research entities, such as the Centers for Disease Control or the National Institutes of Health, from researching firearm violence as a public health issue.

References


**Explanatory Statement:**

The intention behind this resolution is for the AOA to recognize gun violence as a public health issue and to support efforts to research gun violence as such, without taking or making any political stances on the issue. Currently, due to the Dickey Amendment, research on gun violence by entities such as the CDC is prohibited. We strongly feel that such a ban on research goes against basic scientific principles and is antithetical to progress. Research and evidence should be essential to inform our decisions on how to deal with the issue of gun violence. Without said research on gun violence we are at the risk of making policy and decisions as a nation that are not evidence based. We feel calling the attention of lawmakers to repeal of the Dickey Amendment is in the best interest of the public’s health as it will help us make decisions based on the facts and evidence.

**FISCAL IMPACT:**

Unknown

**ACTION TAKEN** DISAPPROVED

**DATE** July 21, 2018
WHEREAS, the American Osteopathic Association (AOA) policy H419-A/16 supports “well-controlled clinical studies on the use of cannabis, commonly referred to as marijuana, and related cannabinoids...and encourages the National Institutes of Health (NIH) to facilitate the development of well-designed clinical research studies into the medical use of cannabis”¹; and

WHEREAS, the Controlled Substances Act of 1970 defines a Schedule I substance, such as cannabis, as having “no currently accepted medical use in treatment”², yet under the Food and Drug Administration’s (FDA) Compassionate Investigational New Drug Program, federally regulated medical cannabis, grown at the University of Mississippi and managed by the National Institute of Drug Abuse (NIDA), is distributed to patients with “serious diseases and health issues for their lifetime”³; and

WHEREAS, twenty-nine states and the District of Columbia have passed legislation to legalize medical cannabis usage when recommended by a physician, yet classification of cannabis has remained the same⁴; and

WHEREAS, several national medical membership organizations such as American Academy of Family Physicians, American College of Physicians, American Academy of Pediatrics, and American Medical Association support reclassification and medicinal use of cannabis, and advocate for expansion in research⁵,⁶,⁷; and

WHEREAS, the National Academies of Sciences, Engineering, and Medicine’s recent publication, The Health Effects of Cannabis and Cannabinoids, states there is “conclusive or substantial evidence that cannabis or cannabinoids are effective for treatment for chronic pain in adults, antiemetic in the treatment of chemotherapy-induced nausea and vomiting, and improving patient-reported multiple sclerosis spasticity symptoms”⁸; and

WHEREAS, “Only two cannabinoid drugs are currently licensed for sale in the U.S. (dronabinol and nabilone)” and “given cannabis’ proven efficacy at treating certain symptoms and its relatively low toxicity, reclassification would reduce barriers to research and increase availability of cannabinoid drugs to patients who have failed to respond to other treatments”⁹,¹⁰; and

WHEREAS, the National Institute of Health spent “$297 million on grants for non-abuse research of cannabis”, but “provided two to four times as much for similar research of opiates and benzodiazepines”¹⁰, which does not include the money spent by pharmaceutical companies to introduce new opioids and benzodiazepines into the opioid market; and
WHEREAS, “As a Schedule I controlled substance under the Controlled Substances Act, cannabis use in a clinical trial requires special licensure”, approval from the FDA, DEA, and NIDA, and generates obstacles other drugs such as cocaine, do not undergo, and thereby advancements in clinical and public health research of cannabis continue to be limited; now, therefore, be it

RESOLVED, the American Osteopathic Association support a review of the classification of cannabis under the Controlled Substance Act of 1970, to facilitate advancement in clinical, public health, patient safety, and health policy research involving medical cannabis use.

References
11. Food and Drug Administration, “Marijuana Research with Human Subjects”, Available at: https://www.fda.gov/newsevents/publichealthfocus/ucm421173.htm
RELEVANT AOA POLICIES:

1) H419-A/16 MEDICAL CANNABIS, RESEARCH ON
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. 2011; reaffirmed as amended 2016

2) H442-A/17 RECREATIONAL MARIJUANA USE BY PHYSICIANS, STUDENTS AND PATIENTS
The American Osteopathic Association (AOA) adopts the “Recreational Marijuana Use by Physicians, Students, and Patients” white paper as its position on the use of recreational marijuana by physicians, students and patients.

After review of the recently released report by the Academies regarding cannabis use, the AOA adopts the following policies:
1. The American Osteopathic Association does not recommend any use of cannabis by physicians and medical students because of patient safety concerns. This statement is supported by the following evidence from the Academies’ report.
2. The American Osteopathic Association does not support recreational use of marijuana by patients due to uncertainties in properties, dosing, and potential for impairment. Recreational marijuana use is legal only as determined by specific state law.
3. The American Osteopathic Association recognizes that the use of marijuana 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 marijuana use.
4. The American Osteopathic Association shall review its policy in light of any new evidence that will be generated by research entities and update this policy as necessary.

FISCAL IMPACT:
Unknown

ACTION TAKEN  APPROVED

DATE  July 21, 2018
WHEREAS, prescription drugs are among the fastest growing segment of healthcare spending, substantially exceeding the rate of inflation, and annual expenditures in the United States pharmaceutical industry now exceed 500 billion dollars and account for a significant portion of the 3.3 trillion dollars spent annually on healthcare, accounting for 17 percent of Gross Domestic Product (GDP)\(^1\),\(^1\); and

WHEREAS, increased medication cost to the patient correlates with decreased patient compliance, and medication compliance is a necessary component of modern healthcare\(^7\); and

WHEREAS, pharmaceutical companies are granted a 20-year patent and period of exclusivity upon FDA approval of a new drug\(^1\); and

WHEREAS, “evergreening” is 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\(^4\); and

WHEREAS, evergreening (also known as “product hopping” and “product switching”) is practiced by pharmaceutical companies in order to reduce competition and prevent equivalent generic drugs from entering the market; moreover, evergreening protects a company’s monopoly on a drug, which leads to significantly increased drug costs for patients\(^2\),\(^8\),\(^9\); and

WHEREAS, India has already taken action to combat the issue of evergreening by The Patents (Amendment) Act of 2005, which does not allow a patent for “a new form of a known substance which does not result in the enhancement of known efficacy of that substance”\(^5\); and

WHEREAS, incentive for innovation in pharmaceuticals is still protected, The Hatch-Waxman Act of 1984 promotes a balance between innovation and competition in pharmaceuticals; furthermore, the Biologics Price Competition and Innovation Act of 2009 has created new incentives for pharmaceutical companies to develop new medications\(^1\),\(^1\),\(^2\); and

WHEREAS, the Federal Trade Commission regulates pharmaceutical companies’ attempts to extend patent life; however, some companies engage in activities that allow them to evade these regulations, with one technique used being “pay-for-delay”, which is when a
competitor files a new drug application (NDA) for a generic drug, the company with the
original patent will pay the competitor in order to prevent equivalent drugs from
entering the market; and

WHEREAS, at present time there is no adequate policy that successfully discourages
evergreening in the United States; and

WHEREAS, in accordance with AOA policy H 638-A/17 Prescription Drug Pricing, the
American Osteopathic Association advocates for policies that encourage access to and
affordability of prescription drugs; additionally, the need for more stringent regulations
regarding evergreening is critical in order to uphold the four tenets of osteopathy
promoting the highest standard of care for our patients; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) advocate for and support 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, in the pharmaceutical sector.

References
Statistics-Data-and-Systems/Statistics-Trends-and-
Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.
2. Alkhafaji et al. Impact of evergreening on patients and health insurance: A meta analysis and
reimbursement cost analysis of citalopram/escitalopram antidepressants. BMC Medicine
2012 10:142.
10(6): e1001460. doi:10.1371/journal.pmed.1001460.
incentives. CMAJ, 185 (11), 939.
Pharmaceutical “Product Hopping” Can Be the Basis for an Antitrust Lawsuit. Retrieved
from https://www.ftc.gov/news-events/press-releases/2012/11/ftc-files-amicus-
briefexplaining-pharmaceutical-product-hopping
10. Federal Trade Commission’s Brief as Amicus Curiae, Mylan Pharmaceuticals Inc. v. Warner

13. Drug prices quoted from Walmart Pharmacy.


Explanatory Statement:
The spirit of this resolution is to further pursue the American Osteopathic Association’s current goal to advocate for policy that promotes fair drug pricing. We view “evergreening” as unnecessary and detrimental to the patient community. Evergreening allows for pharmaceutical companies to prolong their drug patents beyond their current 20 year allowance without actually improving or changing their products in any meaningful way. This keeps drug prices high and unaffordable, getting in the way of our ability to provide care patients need, as patients struggle to afford medications. While we do not oppose the profitability of said companies, we take issue with the current system (evergreening) as it allows companies to extend patents without much innovation or improvement on their existing drugs as the criteria to extend patents is arbitrary. More importantly, evergreening places profitability over the health of patients. While this resolution is in line with the AOA’s current goals, outlined in Resolution H 638-A17 (below), it targets a specific practice (evergreening) that we feel is important for the AOA to address.

H 638-A/17 PRESCRIPTION DRUG PRICING
The American Osteopathic Association (AOA) will advocate for policies that encourage pharmaceutical manufacturers, prescription drug benefit managers, pharmacies, and payers to price drugs and insurance products on prescription drugs in order to promote access, affordability, and continued advancement of healthcare quality and innovation. 2017

FISCAL IMPACT:
Unknown

ACTION TAKEN _APPROVED_____________

DATE _July 21, 2018_____________
WHEREAS, the United States has more gun murders per 100,000 people than any developed
country in the world; and

WHEREAS, there are more than 350 million guns in circulation in the United States,
approximately 113 guns for every 100 people; and

WHEREAS, 93% of Americans support background checks for all gun buyers and 89%
support preventing the mentally ill from buying guns; and

WHEREAS, 22% of guns in the US are legally obtained without a background check; and

WHEREAS, Assault weapons such as the AR-15 are easier to purchase than handguns in some
states because the legal age to purchase rifles is 18 as opposed to 21 for handguns; and

WHEREAS, among mass shootings, the AR-15 has been the weapon of choice in most of the
recent tragedies, including 27 killed at Sandy Hook Elementary School in Newtown,
Connecticut in 2012, 14 killed at work in San Bernardino, California in 2015, 49 killed at
Pulse Nightclub in Orlando, Florida in 2016, 58 killed at a concert in Las Vegas in 2017,
26 killed at First Baptist Church in Sutherland Springs, Texas in 2017, and now 17 killed
at Stoneman Douglas High School in Parkland, Florida in 2018; and

WHEREAS, states that have tightened their gun laws such as Connecticut have seen a decrease
in gun homicide by 40% and decrease in gun suicide by 15% while states that have
loosened their gun laws such as Missouri have seen an increase in gun homicide by 25%
and an increase in gun suicide by 16%; and

WHEREAS, in 1996, Australia passed comprehensive gun violence reform (National Firearms
Agreement) and by 2006, they saw a 59% decrease in gun related homicides; and

WHEREAS, the American Academy of Family Physicians, American Academy of Pediatrics,
American College of Obstetricians and Gynecologists, American College of Physicians,
and American Psychiatric Association have laid out three concrete steps for the
president and Congress to take in order to decrease gun violence:
1. Label violence caused by the use of guns as a national public health epidemic
2. Fund appropriate research at the CDC as part of the 2018 federal budget
3. Establish 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; now, therefore, be it

RES. NO. H-630 - A/2018 – Page 1
RESOLVED, the American Osteopathic Association join physician LIKE-MINDED organizations like the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, and American Psychiatric Association in the call for Congressional legislation that:

1. Labels GUN violence caused by the use of guns as a national public health epidemic ISSUE.

2. Funds appropriate research ON GUN VIOLENCE at the CDC as part of the 2018 FUTURE federal budget.

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.

References
5. FARS 1975–2015 Final File, 2016 ARF; Vehicle Miles Traveled (VMT): FHWA.

Explanatory Statement:
We have a crisis and epidemic in the United States with regards to gun violence, and the authors believe it is within our scope of practice and interest as future physicians to advocate for sensible policies that could help reduce gun violence. Gun reform in the scope of this resolutions has been called for by the AAFP, AAP, and many other prominent national associations. A call for restrictions on high capacity weapons within constitutional boundaries is open enough to allow for specifics to remain a dynamic discussion while at the same time such a call demands for specific action. Beyond working towards protecting public health, adopting this cautiously progressive
policy will place the AOA in line with other major medical organizations and demonstrate the importance we hold for this topic, while increasing our attractability to young physicians.

FISCAL IMPACT:
Unknown

ACTION TAKEN **APPROVED as AMENDED**

DATE  **July 21, 2018**
WHEREAS, societal rejection, discrimination, and violence have contributed to a large number
of LGBTQ-identified individuals who are struggling with substance abuse and
homelessness in the United States; and

WHEREAS, an estimated 20-40% of the more than 1.6 million U.S. homeless youth identifying
With LGBTQ and LGBTQ individuals are more than twice as likely as heterosexual
individuals to use any illicit drug within a year; and

WHEREAS, Halfway Houses are residences that provide structured living in a supported group
environment, attempt to help individuals to overcome addiction, and assist in the
transition from rehabilitation back to the community; and

WHEREAS, the general expectations of residents of Halfway Houses include, but are not
limited to, staying sober (all drugs and alcohol are prohibited within the home),
returning to work after an appropriate amount of time, adherence to a curfew, and
attendance of the 12-step program or other recovery meetings; and

WHEREAS, many halfway houses are often court mandated and conform to state and federal
regulation, in addition, they often receive government funding; and

WHEREAS, the U.S. Department of Housing and Urban Development has required federal
grantees to abide by state and local nondiscrimination rules; and

WHEREAS, there are currently twenty-two states that allow housing discrimination based on
sexual rientation; and

WHEREAS, the current federal regulations and restrictions regarding halfway house
governance are not adequately followed in respect to discrimination against LGBTQ
community members; and

WHEREAS, the gender segregation policy of halfway houses increases exclusion of transgender
individuals, especially those undergoing transitional treatment, resulting in transgender
people being disproportionately denied parole because of a reluctance on the part of
judges to place a transgender person at a halfway house program segregated by gender; and

WHEREAS, social services, halfway houses, and homeless shelters assigned to work with
LGBTQ populations fail to culturally and appropriately serve their needs; including
denying them shelter based on their gender identity, inappropriately housing them in a
WHATSOEVER, young LGBTQ individuals have an elevated risk of suicidal thoughts and attempted suicide; one study found that almost half of young transgender people had serious thoughts about suicide, 26% had attempted suicide, and nearly one-third (29%) of lesbian, gay, and bisexual youth had attempted suicide at least once in the prior year as compared to 6% of heterosexual youth; and

WHEREAS, in a Chicago study, 57% of transgender females aged 16–25 years reported having sex under the influence of drugs or alcohol, and this was significantly associated with both unprotected anal intercourse, and with selling sex; and

WHEREAS, there are currently only a handful of publicly recognized halfway houses in the nation that identify as LGBTQ-specific centers, all of which are privately funded, and most of which only cater to the male gender; and

WHEREAS, many homeless young adults find themselves involved in risky situations like increased drug use as a coping mechanism or engaging in survival sex to get access to shelter, food, drugs, and money; thus leading to increased rates of HIV, sexually transmitted infections, substance abuse, suicidal ideation, and continued psychological trauma; now, therefore be it

RESOLVED, that the American Osteopathic Association supports and advocates for increased for increased awareness of, inclusion of, and resources for the LGBTQ population within government-funded halfway homes; and, be it further

RESOLVED, AOA supports and advocates for the increased monitoring and regulation of government-funded halfway homes in respect to discrimination against sexual orientation, gender identity, and/or gender expression.

References

Reference Committee Explanatory Statement:
The Committee believes that the proposed resolution is overly narrow in its scope and that much of its content is memorialized in policy H439-A/2016 (“Lesbian, Gay, Bisexual, Transgender, Queer / Questioning Protection Laws”).

ACTION TAKEN DISAPPROVED

DATE July 21, 2018
WHEREAS, the overall rate of drug overdose and overdose related deaths are rapidly increasing nationwide with opioids and opiates implicated in the vast majority of cases; and

WHEREAS, according to the Center for Disease Control and Prevention (CDC), the number of reported deaths from drug overdose has increased 8.6-fold from 1980 to 2015; and

WHEREAS, in 2015, 52,404 deaths were due to drug overdose with opioids/opiates accounting for 73.7% (38,597 deaths); and

WHEREAS, the CDC’s National Center for Health Statistics (NCHS) reports, “In 2015, the percentage of drug overdose deaths involving heroin (25%) was triple the percentage in 2010 (8%).”; and

WHEREAS, on July 22, 2016, The Comprehensive Addiction and Recovery Act (P.L. 114-198) (CARA) was signed into law. The law represents a comprehensive effort to address the opioid epidemic in our nation by encompassing all six pillars necessary for such a coordinated response – prevention, treatment, recovery, law enforcement, criminal justice reform, and overdose reversal; and

WHEREAS, the AOA in the past has applauded Congress for passing the Comprehensive Addiction and Recovery Act (CARA); and

WHEREAS, population analysis from the Boston Community-bystander Overdose Educational and Naloxone Program has demonstrated lower rates of overdose death in towns with over 150 individuals trained in the use of intranasal naloxone per 100,000 people; and

WHEREAS, as of February 2nd, 2016 Naloxone may be dispensed with a prescription in all 7,800 CVS stores nationwide with 14 states allowing non-prescription sale of Naloxone; and

WHEREAS, Naloxone does not have abuse potential since it does not produce subjective effects or physical dependence and is only effective when opioids are present; and

WHEREAS, data from the CDC reported that after the implementation of community-based
training programs and distribution of Naloxone to 53,032 persons in 2010, nearly 10,171 successful overdose reversals were achieved; now, therefore be it

RESOLVED, the American Osteopathic Association supports preventative prescribing of Naloxone and the education and training of its use for patients at risk of overdose, family members, and caregivers, in order to prevent opioid / OPIATE related deaths.

References

ACTION TAKEN APPROVED as AMENDED

DATE July 21, 2018
WHEREAS, there are an estimated 11 million undocumented immigrants living in the United States (U.S.); and

WHEREAS, 5.3 million children are living with undocumented immigrant parents, 85% of these children are U.S.-born citizens; and

WHEREAS, 8 million of these undocumented immigrants are employed and most have resided in the U.S. for more than a decade; and

WHEREAS, these working immigrants pay $13 billion in payroll taxes while only collecting $1 billion in benefit payments; and

WHEREAS, 60% of undocumented immigrant adults and 77% of children have private health insurance; and

WHEREAS, fear of deportation has been associated with poorer self-perceived health and activity limitation following U.S. Immigration and Customs Enforcement (ICE) Raids and emotional distress for both documented and undocumented immigrants; and

WHEREAS, almost half of providers in a 2013 study directly observed the negative effects of ICE enforcement on the health or health access of their immigrant patients; and

WHEREAS, undocumented immigrants reported avoiding health care and waiting until health issues were critical to seek services because of their concerns of being reported to authorities; and

WHEREAS, total arrests, book-ins, interior deportations and non-criminal deportations increased in fiscal year 2017 as compared to the two years before according to ICE data; and

WHEREAS, ICE currently has a sensitive locations policy that ensures that actions should not be taken on sensitive locations (including hospitals) unless exigent circumstances exist, other law enforcement actions have led officers to a sensitive location, or prior approval has been obtained; and

WHEREAS, the Protecting Sensitive Locations Act, H.R. 1815, has recently been introduced in Congress and its purpose is to confirm the ICE sensitive locations policy and clarify the powers of immigration officers at these facilities; and
WHEREAS, even with the sensitive locations policy and introduced legislation, there have still been recent increases in the amount of ICE raids carried out in sensitive locations, including hospitals, that have made it even more difficult for undocumented immigrants to access the US healthcare system; and

WHEREAS, many of these instances were included in a 2017 JAMA article, one of which states that, “In February 2017, Sara Beltran-Hernandez, a 26-year-old undocumented immigrant, was bound by her hands and feet and removed by wheelchair from a Fort Worth, Texas, hospital by ICE agents while she was awaiting emergency brain surgery.”; and

WHEREAS, the American Osteopathic Association (AOA) already has a policy, H619-A/17, in place that protects physicians from being held responsible for identifying the legal status of a patient; and

WHEREAS, SOMA has a policy, Res-S-15-09, that declares that healthcare is a human right as a fundamental principle; and

WHEREAS, the World Health Organization (WHO) outlines health as a fundamental human right to be enjoyed by every human being without discrimination and that vulnerable and marginalized population groups require priority attention in their International Migration Health and Human Rights Publication; now, therefore be it

RESOLVED, the American Osteopathic Association (AOA) oppose the presence and actions defined as ICE sensitive locations; and, be it further,

RESOLVED, that the AOA lobby and advocate for federal policies that reinforce hospitals and other healthcare facilities as sensitive locations and discourage any ICE officials or officers from carrying out actions in these areas; and, be it further,

RESOLVED, that the AOA encourage healthcare facilities to clearly demonstrate and promote their status as sensitive locations, educate their employees on their rights in these instances, and ensure the privacy and safety of some of our most vulnerable populations while also decreasing their barriers to care; and, be it further,

RESOLVED, that SOMA advocate to, and collaborate with, the AOA to create a document that clearly explains our rights and the rights of our patients in these difficult situations as to be available on the AOA website or distributed to healthcare facilities across the nation to be used for display or educational purposes.

References

Explanatory Statement:  
Lately we have seen many stories in the news from multiple different sources that have appalled us at the way ICE enforcement actions have been handled at sensitive locations, especially hospitals and other healthcare facilities. We feel as though this is a breach of our privacy in the patient-provider relationship and a breach of the safety and inclusiveness that we try so hard to provide at our clinics around the country. This goes against medical ethics and is not in keeping with the oath we take upon becoming physicians, as it puts an already vulnerable population at more undue risk. The fear of
deportation prevents this population from accessing care which leads to worse health outcomes, more emergency department visits, and more expensive care. That is why we believe that these types of immigration actions at healthcare facilities should be opposed until physicians and patients feel completely safe in these sensitive locations. Of note, the AMA house of delegates recently adopted a directive (D-160.921) that hospitals, clinics and medical facilities should be designated as sensitive locations by law and thus off limits to entities such as ICE.

Reference Committee Explanatory Statement:
The Committee believes that the proposed regulation lacks clarity and fails to fully recognize ICE’s previously issued and implemented policy concerning enforcement actions at sensitive locations. Medical treatment and health care facilities, such as hospitals, doctors’ offices, accredited health clinics, and emergent or urgent care facilities, are considered sensitive facilities under current federal policy; thus, enforcement actions may only take place in certain, limited circumstances.

ACTION TAKEN **DISAPPROVED**

DATE **July 21, 2018**
WHEREAS, sexual violence is defined as a sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse; and

WHEREAS, sexual assault is defined as any type of sexual contact or behavior that occurs without the explicit consent of the recipient; and

WHEREAS, sexual violence has serious consequences on physical, mental, sexual and reproductive health; and

WHEREAS, a sexual assault medical forensic exam is an examination conducted by a health care provider which includes gathering the medical forensic history, treating injuries, documenting biological/physical evidence findings, administering a sexual assault evidence collection kit for evidence collection, and providing treatment information for STIs, pregnancy, suicidal ideation, alcohol and substance abuse; and

WHEREAS, rape has been reported as the crime having the highest lifetime cost to the victim and it has been estimated that each rape costs approximately $151,423; and

WHEREAS, the Violence Against Women Reauthorization Act of 2013 requires state, tribal and local governments to offer medical forensic examinations to victims of sexual assault without regard to whether the victim participates in the criminal justice system or cooperates with law enforcement; and

WHEREAS, medical forensic examinations must be provided at no cost to the victim, with federal reimbursement for costs incurred by state, tribal and local governments under the STOP Violence Against Women Formula Grant Program; and

WHEREAS, sexual assault evidence collection kit storage policies vary across jurisdictions, resulting in some kits being discarded in as little as 30 days or kits being discarded before the state-specific statute of limitations which can expire in as little as 3 years; and

WHEREAS, requiring sexual assault survivors to repeatedly request extensions for the preservation of their kits, especially if they remain undecided about pursuing legal action, places an undue burden on the survivor with consequences to their mental health and recovery; and

WHEREAS, sexual assault survivors are sometimes given no information about the testing, results, or destruction of their kits; and
WHEREAS, some states do not guarantee that all legal rights of a crime victim will be protected for sexual assault survivors; and

WHEREAS, state laws has resulted in sexual assault survivors sometimes being charged for their own evidence collection kit or associated treatments; and

WHEREAS, sexual assault survivors are sometimes not informed about their legal options; and

WHEREAS, the federal Survivors’ Bill of Rights Act of 2016 (SBRA) was passed by Congress and signed into law to address these challenges faced by sexual assault survivors; and

WHEREAS, SBRA establishes that a survivor of sexual assault has the right to receive a medical forensic examination at no cost, that the evidence collection kit be preserved, without charge, for the duration of the statute of limitations or 20 years, that the survivor be informed of the results of the kit, that the survivor be notified of plans to destroy the kit, that the survivor be granted further preservation of the kit if requested, and that the survivor be informed of these rights; and

WHEREAS, the Federal government is limited in its ability to change law enforcement practices at the State level and since the provisions of SBRA involve elements of law enforcement, adopting the federal standards set by SBRA can only be accomplished by individual State legislation; and

WHEREAS, nine states have passed legislation similar to the Survivors’ Bill of Rights Act of 2016, six additional states have introduced similar legislation, and nineteen states have ongoing advocacy efforts to consider similar legislation; and

WHEREAS, all citizens should have an opportunity to avail themselves of these crucial rights; and

WHEREAS, SBRA instructs the Attorney General and the Secretary of Health and Human Services to establish a joint working group, including the medical provider community, to develop, coordinate, disseminate and encourage implementation of best practices regarding the care of sexual assault survivors and the preservation of evidence among hospital administrators, physicians, forensic examiners, medical community leaders, and medical associations; and

WHEREAS, existing policy does not specifically address the medical-legal rights of sexual assault survivors or the need for collaboration between the medical and legal communities in addressing this pressing public health issue; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) advocate for the legal protection of sexual assault survivors’ rights as defined by the Survivors’ Bill of Rights Act of 2016 which include but are not limited to, the right to:

1. Receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing and treatment, access to emergency contraception, treatment of injuries, and collection of forensic evidence;
(2) Preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation;
(3) Notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation;
(4) Be informed of these rights and the policies governing the sexual assault evidence kit.

References


ACTION TAKEN **APPROVED as AMENDED**

DATE **July 21, 2018**
WHEREAS, the American Osteopathic Association (AOA) policy H315-A/13 states that “all 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 him or her from providing a medically-approved service, they should recuse themselves from the case and refer the patient to another provider”; and

WHEREAS, the AOA guidelines on professional conduct recognize beneficence, dignity, and autonomy as ethical tenants that should guide physicians in their professional activity. These elements are described as such: beneficence—a physician should act in the best interest of the patient and place the needs of the patient first; dignity—the patient has the right to dignity, truthfulness and honesty; and autonomy—the patient has the right to refuse or choose their treatment; and some individuals with opioid addictions seek opioids from multiple prescribers, known as “doctor shopping”, and will cross state lines to procure painkillers, and since most PDMPs are state-based systems, physicians cannot retrieve past medical history on these patients, which contributes to the growing opioid epidemic; and

WHEREAS, section two of the AOA code of ethics states that the physician shall give a candid account of the patient's condition to the patient or to those responsible for the patient's care. The AOA considers it a responsibility of the physician provide patients with an understanding of their health status and the potential consequences of decisions regarding treatment and lifestyles. Section four of the code of ethics states that a physician is never justified in abandoning a patient, and that the physician shall give due notice to a patient or to those responsible for the patient's care when she/he withdraws from the case so that another physician may be engaged; and

WHEREAS, several legal statues protect the rights of individuals and entities to abstain from certain activities related to health care services without discrimination or retaliation, including the Coats-Snowe, Weldon, and Church Amendments. These statutes explicitly allow health care clinicians with a moral objection to a treatment or procedure to refuse to participate in, assist with, refer for, or counsel a patient about such procedures, including but not limited to abortion, sterilization, and physician assisted suicide; and

WHEREAS, the Department of Health and Human Services (HHS) recently issued a draft of new conscience regulation titled Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, applying to all programs partially or totally funded or administered by HHS; the department’s reasoning for the rule is to “ensure knowledge, compliance, and enforcement of the federal health care conscience laws.” With the rule, HHS also created a Division of Conscience and Religious Freedom to “provide HHS with the focus it needs to more vigorously and effectively enforce existing laws
protecting the rights of conscience and religious freedom. However, the HHS Office of Civil Rights (OCR) already has authority over enforcement over all non-discrimination laws, including conscience laws; and

WHEREAS, HHS announced the new rule and division as “two major actions to protect life the conscience rights of Americans,” and stated that the actions will “guarantee justice to victims of unlawful discrimination.” This rule’s definition of discrimination focuses primarily on discrimination by states, agencies, or employers who make unavailable grants, contracts, licenses, employment, or other privileges, as well as those who “utilize any criterion that tends to subject individuals or entities protected under this part to any adverse effect.” The proposed rule does not discuss patients who have been victims of discrimination or provided sub-standard care by providers on the basis of their beliefs, identity, or health care choices; and

WHEREAS, the HHS OCR does not prohibit discrimination on the basis of gender identity or termination of pregnancy; and

WHEREAS, rather than specifically defining a health care entity, the HHS rule protects all “members of the workforce,” and specifies that the list provided in the rule is illustrative and not exhaustive. The rule also defines to assist in the performance of a procedure as any activity with an articulable connection to the procedure, rather than restricting the definition only to those directly involved in the procedure; and

WHEREAS, the rule defines refer for as including the provision of any information that could provide any assistance in a person obtaining, training in, financing, or performing a particular health care service when the health care entity understands that service to be the possible outcome of the referral. The rule specified that “a referral would include such activities as providing to a patient seeking abortion contact information of a physician of clinic that may provide an abortion, or telling a patient that funding is available for abortion and providing a phone number where she can be referred to abortion services or funding”; and

WHEREAS, the issues of conscience and religious freedom are currently being utilized by several state senates as a tool to pass legislation that allows healthcare providers to act unethically by withholding information from their patients. For example, several states, including Arizona, Kansas, and Texas have enacted or proposed laws that protect physicians who withhold birth defect or fetal abnormality information from pregnant women to prevent them from requesting abortions; and

WHEREAS, several national advocacy organizations, including the American Civil Liberties Union, National Women’s Law Center, and National LGBTQ Task Force, believe that the new rule will allow providers to discriminate in providing care, placing provider’s beliefs over the autonomy and civil rights of their patients. Particular concerns are denial of care services based on a patient’s identity or past health decisions, obstruction of access to time sensitive care and procedures by any member of the care-continuum, including ambulance drivers, physicians, nurses, receptionists, schedulers, and pharmacists, and the fact that “the rule does not even require that patients be informed of the individual’s or entity’s refusal to provide care,
information, referrals, or other services, leaving patients unaware that they might not be
getting the care they need from someone in whom they have placed their trust12”; and

WHEREAS, many of the protections detailed under the new regulation and HHS division are
directly contrary to the AOA policy, ethical codes, and professional expectations.
Physicians are allowed limited autonomy to govern conduct within their own profession
through participation on state licensing boards2, and these boards may conclude that
behaviors protected under the law are nonetheless contrary to our code of ethics; now,
therefore be it

RESOLVED, that the American Osteopathic Association (AOA) release a statement that it will
stand against any efforts of the HHS Division on Conscience and Religious Freedom
that would infringe upon patient autonomy or allow for the discrimination of,
abandonment of, or withholding information from patients who choose lawful elective
procedures or therapies that conflict with a healthcare provider's religious and/or moral
beliefs, including, but not limited to: gender-affirming therapies and/or procedures,
abortion, physician assisted death, and contraception use.

References
2. American Osteopathic Association, “AOA Rules and Guidelines on Physicians' Professional Conduct,” Available at:
   https://www.osteopathic.org/insideaoa/about/leadership/Pages/aoa-rules-and-guidelines-on-physicians-professionalconduct.aspx
3. American Osteopathic Association, “AOA Code of Ethics,” Available at:
   http://www.osteopathic.org/inside-aoa/about/leadership/Pages/aoa-code-of-ethics.aspx
4. Health and Human Services Department, “Protecting Statutory Conscience Rights in Health Care; Delegations of Authority,” Available at:
5. Health and Human Services Department, “HHS Takes Major Actions to Protect Conscience Rights and Life,” Available at:
6. Health and Human Services Department, “HHS Announces New Conscience and Religious Freedom Division,” Available at:
   Available at: https://www.hhs.gov/civil-rights/for-individuals/section1557/1557faqs/index.html
8. State of Arizona, “Senate Bill 1359,” Available at:
   https://www.azleg.gov/legtext/50leg/2r/bills/sb1359s.htm
9. Legiscan, “Texas Senate Bill 25,” Available at
   https://legiscan.com/TX/text/SB25/id/1548615
10. Justia, “2014 Kansas Statutes,” Available at:
    https://law.justia.com/codes/kansas/2014/chapter-60/article-19/section-60-1906/

12. National Women’s Law Center, “Trump Administration Proposes Sweeping Rule to Permit Personal Beliefs to Dictate Health Care,” Available at: https://nwlc.org/resources/trump-administration-proposes-sweeping-rule-to-permitpersonal-beliefs-to-dictate-health-care/


14. The United States Department of Justice, “Civil Rights Offices of Federal Agencies,”
   Available at: https://www.justice.gov/crt/fcs/Agency-OCR-Offices#1

Explanatory Statement:
Each federal agency has its own Office of Civil Rights charged with enforcing all anti-discrimination and civil rights statutes, including conscience protections. On January 18th, 2018, the Department of Health and Human Services announced new conscience regulation as well as the creation of a Division of Conscience and Religious Freedom. The Department estimates that implementation of this rule will, on average, cost $312.3 million in year one and $125.5 million annually in years two through five. Many advocacy groups have taken strong stances on the new rule and division, but major medical groups, including the American Osteopathic Association and the American Medical Association have yet to make a public comment on the new regulations. It is our belief that the duty of a physician is primarily to help and heal others. There is no room for physicians to pass judgement on patients, especially to the extent that such judgement may compromise or interfere with patient autonomy. Physicians retain the right to refer patients they are unwilling to provide care for due to personal beliefs, as defined by our ethical standards to uphold our medical licenses. However, no patient should ever be denied care based on the personal morals of a physician. We strongly believe such denial of care is antithetical to the practice of medicine and warrants an explicit stance by the AOA.

Reference Committee Explanatory Statement:
The Committee believes that the proposed resolution is addressed by AOA policy H315-A/2013 (“Health Care Providers Rights of Conscience”).

ACTION TAKEN  DISAPPROVED

DATE  July 21, 2018
WHEREAS, the United States (U.S.) Department of Justice defines restrictive housing as the removal of inmates, subsequent placement in a cell isolated from the general prison population, and an inability to leave the room for 22 hours or more; and

WHEREAS, although there is no universal definition of solitary confinement, the United Nations General Assembly Interim Report defines it as “the physical and social isolation of individuals who are confined to their cell for 22 to 24 hours a day,”; and

WHEREAS, more than 95,000 youths under the age of 18 were placed in jails and prisons throughout the United States in 2011, and while tracking data for the prevalence of the use of solitary confinement and/or restrictive housing among juveniles is not publically available, the practice is known to be widespread throughout the U.S.; and

WHEREAS, juvenile inmates can be placed under solitary confinement without a definitive court decision; and

WHEREAS, incarceration alone yields unintentional but inevitable consequences for the mind, solitary confinement amplifies the risk of anxiety, depression, psychosis and self harm according to both the American Psychological Association and American Academy of Child and Adolescent Psychiatry; and

WHEREAS, although the body is not the object of penalization in prison systems, the mind-body connection alone yields unintentional but inevitable consequences on wellness; and

WHEREAS, according to the World Health Organization, the life expectancy of individuals with severe mental health disorders is 10-25 years less than the general population. Physical manifestations of disease in persons with severe mental health disorders include cardiovascular disease, type II diabetes, respiratory disease, and infections such as HIV, hepatitis, and tuberculosis; and

WHEREAS, inmates who were ever assigned to solitary confinement are 3.2 times as likely to commit acts of self-harm, and of the juveniles that complete suicide in prison, half of those victims were in isolation at the time of suicide, and 62% of those same individuals had a history of solitary confinement; and

WHEREAS, federal legislation including the MERCY Act and the Protecting Youth from Solitary Confinement Act have already been introduced in the U.S. Senate and House of
Representatives respectively, and still, 21 states and the federal government have no laws restricting the use of solitary confinement and/or restrictive housing among youths; and

WHEREAS, the American Academy of Pediatrics cites the findings of the UN Convention on the Rights of the Child in advocating for the abolishment of the use of solitary confinement and isolation for incarcerated youth; and

WHEREAS, the U.S. Supreme Court reaffirmed in Miller v. Alabama that the ultimate purpose of the juvenile prison system is rehabilitation, and restrictive housing limits opportunities to participate in programming aimed towards this end; now, therefore be it

RESOLVED, that 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; and, be it further

RESOLVED, that the AOA stand against the use of solitary confinement and/or restrictive housing of juveniles in prison systems.

References


Reference Committee Explanatory Statement:
The Committee requests that Bureau of Scientific Affairs and Public Health (BSAPH) study the frequency and impact of solitary confinement and isolation on juvenile well-being.

ACTION TAKEN REFERRED (to BSAPH)

DATE July 21, 2018
SUBJECT: URGING CONGRESS TO RETAIN SUPPORTING POLICY THAT ACCOMMODATES DACA STATUS PROTECTIONS

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, on June 15, 2012, President Obama announced the program, Deferred Action for Childhood Arrivals (DACA), which would bring changes to policies within the Department of Homeland Security, granting those who came to the U.S. before the age of 16 an opportunity to request deferred action for a period of two years and also become eligible for work authorization, subject to renewal processes; and

WHEREAS, one was eligible to request to be protected under DACA if one: 1. Were under the age of 31 as of June 15, 2012; 2. Came to the United States before reaching their 16th birthday; 3. Have continuously resided in the United States since June 15, 2007, up to the present time; 4. Were physically present in the United States on June 15, 2012, and at the time of making their request for consideration of deferred action with United States Citizenship and Immigration Services (USCIS); 5. Had no lawful status on June 15, 2012; 6. Are currently in school, have graduated or obtained a certificate of completion from high school, have obtained a general education development (GED) certificate, or are an honorably discharged veteran of the Coast Guard or Armed Forces of the United States; and 7. Have not been convicted of a felony, significant misdemeanor, or three or more other misdemeanors, and do not otherwise pose a threat to national security or public safety; and

WHEREAS, 800,000 young adult unauthorized immigrants ("DREAMers") have been protected against deportation since June 2012; and

WHEREAS, 69% of DREAMers got a job with better pay, 61% opened their first bank account, 65% bought first car, 65% pursued education opportunities they previously could not; and

WHEREAS, a 2017 study revealed that the average age at which DACA recipients arrived in the US was 6-and-a-half years old; and

WHEREAS, the Association of American Medical Colleges (AAMC) predicts that the doctor shortage will rise between 40,800 and 104,900 by 2030, as the population ages and more people gain access to health coverage; and

WHEREAS, the American Medical Association (AMA) estimates that the DACA program could add 5,400 previously ineligible physicians into the medical workforce in the coming decades; and

WHEREAS, the AMA believes that removing those with DACA status will create care shortages for rural and other underserved areas because DACA physicians are more
likely to work in high need areas where communities face challenges in recruiting other physicians; and

WHEREAS, DACA-protected physicians tend to be bilingual and come from more diverse cultural backgrounds which help them better understand the challenges that certain ethnic communities face; and

WHEREAS, there are currently 65 DACA-protected students enrolled in medical school and 12 in residency programs; and

WHEREAS, the AAMC estimates a single physician regularly takes care of an average of 1,500 patients a year, thus multiplying the 65 DACA status students currently in medical school by 1,500 totals to nearly 100,000 future patients who will be affected if these students are unable to finish their medical training; and

WHEREAS, on September 5th 2017, the current administration announced that DACA will be “phased out” in six months and urged Congress to act by March 2018; and

WHEREAS, the American Medical Association, Latino Medical Student Association, American College of Physicians, American Academy of Pediatrics, Association of American Medical Colleges, and over 9,000 medical students have spoken in support of DACA medical students and support congress passing legislation to retain DACA protections; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports Deferred Action for Childhood Arrivals (DACA) medical students, residents and physicians; and, be it further

RESOLVED, that the AOA support and urge Congress to pass legislation that would retain DACA protections COMPREHENSIVE IMMIGRATION LEGISLATION THAT ACCOMODATES AND RESOLVE DACA STATUS.

References


Explanatory Statement:
In 1986, President Reagan signed the Immigration Reform and Control Act, which attempted to increase accountability of employers’ hiring practices and legalized immigrants who entered the United States unlawfully before 1982.

In 1996 President Clinton signed the Illegal Immigration Reform and Immigrant Responsibility Act, which significantly increased punishment for unlawful presence in the United States, resulting in deportation and a ten-year ban from the country unless a waiver was obtained.

In 2001, the DREAM Act was introduced in the Senate as a bipartisan bill by Sen. Orrin Hatch (R-UT) and Sen. Maria Cantwell (D-WA), which sought an multi-step approach that would first grant conditional residency for “alien minors” in the United States and, after meeting further qualifications, permanent residency.

After decades of debate, the U.S. Congress has not appropriately answered the call to find humane immigration solutions. DACA is not a comprehensive immigration plan. It has been an attempt to provide a short-term solution for young people who were brought to the United States unlawfully at no fault or decision of their own. These are young people who often only know this country and want to be a part of its fabric.

In addition to retaining DACA protections, the writers of this resolution would also hope for a comprehensive immigration plan at a later time, but for now, this is an immediate call for protecting DACA beneficiaries, so they have a lawful way to work or attend school and continue to contribute to this country that they call home.

ACTION TAKEN _APPROVED as AMENDED_

DATE _July 21, 2018_